

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Glenn Dale, Md. - RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 month, 24 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 2 month, 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1707- W. Virginia Ave., N.E.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BARTON, KATHLEEN DEIRDRE

## 3. (b) Social Security Number

577-18-3597

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Matthew Barton  
 6. (c) If alive, give age 2 years  
 7. Birth date of deceased (mo., day, yr.) Aug. 15, 1909  
 8. AGE: Years 36 Months 11 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ireland  
 (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business \_\_\_\_\_

12. Name John Kelley

13. Birthplace Ireland

14. Maiden name ? O'Donnell

15. Birthplace Ireland

16. Informant deceased

Address \_\_\_\_\_

17. removal Date thereof Aug 5 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington D.C.

18. Funeral director Albert J. Ashe

Address 641 H St. N.E., Washington, D.C.

19. 8/5 46 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 19 46 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46 to Aug 4 19 46 and that I last saw her alive on Aug 4 19 46

Immediate cause of death Pulmonary Tuberculosis DURATION 4 mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinicane MD. M. D. or other

Address Glenn Dale Md. Date signed 8-4-46

RECEIVED  
AUG 9 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

68219

Reg. Diat. No. 245

## 1. PLACE OF DEATH:

County..... Prince George Co.

City or town..... Hyattsville, (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 24 days

Hospital, institution, or street address where death occurred:

Mother Jones Rest Home

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montg,

City or town..... Germantown Md,  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Richard Allen Bennett

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife.....

Sophie Bennett

7. Birth date of  
deceased (mo., day, yr.)

Feb 2nd 1864

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

1864

82

6

26

.....hrs. ....min.

9. Birthplace.....

Germantown Md,

(Town, county, and state)

10. Usual occupation.....

Retired Clerk

11. Industry or business

II

FATHER

12. Name.....

Richard H Bennett

13. Birthplace

Md,

MOTHER

14. Maiden name.....

Sovilla Miles

15. Birthplace

Md,

16. Informant.....

Mrs Charley Gue

Address

Germantown, Md,

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

8/30/46

(month) (day) (year)

Cemetery or crematory.....

Neelsville Cemetery

Location.....

Neelsville. Md,

18. Funeral director.....

Ernest C Gartner

Address

Gaithersburg Md,

19.

(Date rec'd by registrar)

1946

James Leroy

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 28 1946 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April - 2 - 1941, to Aug - 28 - 1946  
and that I last saw him alive on Aug - 15 - 1946

Immediate cause of death.....

exhaustion

DURATION

Due to.....

senility

4-5 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

William C. Miller, M.D.

M. D. or other

Address..... Gaithersburg, Md, Date signed 8/29/46

RECEIVED  
SEP 2 1944  
BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 yrs., 6 mos., 14 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 11 yrs., 6 mos., 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1937 - 14th St. N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war — ✓

## 3. (a) FULL NAME

RICHARD BEVERLY

## 3. (b) Social Security Number

—

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Grace Beverly

7. Birth date of deceased (mo., day, yr.) November 15, 1909  
 6. (c) If alive, give age ? years

8. AGE: Years 36 Months 9 Days 14 If less than one day — hrs. — min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name ? (Died when patient was 7 yrs. old)

13. Birthplace

14. Maiden name ?

15. Birthplace

16. Informant Decedent

Address

17. Removal Date thereof Aug 30 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Rockville Md18. Funeral director Robert L. SnowdenAddress Rockville Md

19. Aug. 29, 46 Rowland S. Philips  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29th 1946, at 4:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15th 1937 to Aug 29th 1946  
 and that I last saw him alive on Aug 29th 1946

Immediate cause of death

Pulmonary Tuberculosis DURATION 11 yrs 5 mos  
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other

Address Glenn Dale Md Date signed 8/29/46

RECEIVED

SEP 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94-0

## CERTIFICATE OF DEATH

08221

Reg. Diat. No. 239

## 1. PLACE OF DEATH:

County Prince George **WITHIN CORPORATE LIMITS OF**City or town Laurel, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 years

Hospital, institution, or street address where death occurred:

314 Montgomery Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. GeorgeCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. 314 Montgomery Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry A. Block

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Stella May Black

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 18728. AGE: Years 73 Months 9 Days 1 If less than one day..... hrs. .... min.9. Birthplace Lithuania  
(Town, county, and state)10. Usual occupation Merchant11. Industry or business Dry goods store12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Albert BlackAddress 314 Montgomery Ave17. Burial Buried Date thereof Aug. 18, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hebrew Friendship CityLocation Baltimore, Maryland18. Funeral director De Witt SchallmanAddress Laurel, Maryland19. Aug 18 1946 M. Brashear  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1938 to Aug 16 1946  
and that I last saw him alive on Aug 16 1946Immediate cause of death Coronary Thrombosis DURATION 2 yrs.Due to Arteriosclerosis 5 yrs.

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Mens of injury Injured at work?

23. SIGNATURE J. M. Mason M.D. M. D. or otherAddress Laurel Date signed 8/16/46

AUG 20 1946  
BUREAU V S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

## CERTIFICATE OF DEATH

18222

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Transient  
 Hospital, institution, or street address where death occurred:  
Croft Highway 1 mile north of Williams  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Penn County Pittsburg  
 City or town Pittsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 409 1/2 Carnegie  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Charles Ellesworth Boden

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 13, 1928  
 8. AGE: Years 18 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pittsburgh, Pa.  
 (Town, county, and state)  
 10. Usual occupation Seaman 2nd class  
 11. Industry or business U. S. Navy  
 12. Name Charles Ellesworth Boden  
 13. Birthplace Pittsburgh, Pa.  
 14. Maiden name Genevieve Ackerman  
 15. Birthplace Pittsburgh, Pa.

16. Informant U. S. Navy Records  
 Address Dispensary Wash. D.C.  
 17. Removal Removal Date thereof Aug. 26, 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Washington D. C.  
 18. Funeral director W. W. Chambers Co.  
 Address 1400 - Chapin St. N. W. Wash. D.C.

Aug 26 19 46 Carrie Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1946 at 5:30 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Hemorrhage and shock  
fracture of skull  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 8-24-46  
 Where did injury occur Upper Marlboro (City or town) P. J. (County) MD (State)  
 Injured at home, farm, industry, public place (where?) State Road  
 Means of injury Tham from motor vehicle work? no  
 23. SIGNATURE James J. Boyd M. D. or other \_\_\_\_\_  
 Address Freshville Md Date signed 8-26-46

RECEIVED  
AUG 27 1946  
BUREAU 4 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 400

8223

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town C. Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? one year  
 Hospital, institution, or street address where death occurred:  
5706 Nyl Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town C. Chapel Oaks  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5706 Nyl Street  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Ola Aberdeen Brandon

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Shepard A. Brandon  
 7. Birth date of deceased (mo., day, yr.) Dec. 6, 1920 6. (c) If alive, give age 27 years  
 8. AGE: Years 25 Months 8 Days 10 If less than one day  
 hrs. min.

9. Birthplace Moneta, Virginia  
 (Town, county, and state)  
 10. Usual occupation None

## 11. Industry or business

FATHER 12. Name Oley Mayo  
 13. Birthplace Nelson County, Va.  
 MOTHER 14. Maiden name Emma Lee Martin  
 15. Birthplace Bedford County, Va.  
 16. Informant Alma Rose Lincoln Mayo  
 Address 5712 Rome St. (Brother)

17. Burial Burial Date thereof Aug. 18, 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Moneta Va  
 Location Va.

18. Funeral director Malva J. Schey  
 Address 424 R St. NW

19. Aug. 16 19 46 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1, 1946 to August 15, 1946  
 and that I last saw him alive on August 15, 1946

Immediate cause of death Acute Hemorrhagic Nephritis DURATION 3-4 wks.

Due to Cancer of the Uterus unknown

Due to not known

Other conditions not known

(Include pregnancy within 3 months of death)  
 Major findings of operations not known

Autopsy results not known  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide not known Date of not known  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury not known Injured at work?

23. SIGNATURE John W. Robinson, M.D. M. D. or other  
 Address 1001 Eastern Ave, NE. Date signed 8/15/46

RECEIVED  
AUG 19 1946  
BUREAU OF S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No.

18224  
239

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Transient  
 Hospital, institution, or street address where death occurred:  
Dr. W. B. Stewart's Office  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State North Carolina  
 City or town Benson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 103 W - Church Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Charles Rufus Brutt

## 3. (b) Social Security Number

240-22-3099

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Charles Brutt  
 6. (c) If alive, give age 42 years  
 7. Birth date of deceased (mo., day, yr.) Sept. 24 - 1962  
 8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Benson, N. C.  
(Town, county, and state)10. Usual occupation Plumber

11. Industry or business

MOTHER FATHER  
 12. Name Albert P. Brutt  
 13. Birthplace North Carolina  
 14. Maiden name Baszelle Hall  
 15. Birthplace North Carolina

16. Informant Madison B. PorterAddress 1446 Howard Street NW Wash DC

17. Married Date thereof Aug 12, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BensonLocation North Carolina18. Funeral director Ridgely SellesAddress 401 West 1st Street Laurel Md

19. August 10 19 46 Car E. Wachter  
 (Date recd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 46 at 640 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 \_\_\_\_\_ to 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

acute congestive heart failureDue to toxic myocarditisDue to alcoholism

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

deputy medical examiner23. SIGNATURE James J. Ford M. D. or other \_\_\_\_\_Address Freshville Md Date signed 8-9-46

RECEIVED

AUG 13 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30-D Ridge Rd.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

## CERTIFICATE OF DEATH

SS. No 579-18-2504

18225-15

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County <u>PRINCE GEORGE</u> City or town <u>BERWYN HEIGHTS</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 YEARS</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>MARYLAND</u> County <u>PRINCE GEORGE</u> City or town <u>BERWYN HEIGHTS</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>8418 - CUNNINGHAM DRIVE</u> (If rural, give LOCATION) 2. (a) If veteran, name war <u>NONE</u>			
<b>3. (a) FULL NAME</b> <u>CHARLES A. BROWN</u>				<b>3. (b) Social Security Number</b> <u>579-18-2504</u>			
<b>4. Sex</b> <u>MALE</u> <b>5. Color or race</b> <u>WHITE</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>MARRIED</u>				<b>MEDICAL CERTIFICATION</b>			
<b>6. (b) Name of husband or wife</b> <u>REGINA A. BROWN</u> <b>6. (c) If alive, give age</b> _____ years				<b>20. DATE OF DEATH</b> <u>August 8</u> , 19 <u>46</u> , at <u>3:55 A.M.</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>APRIL 23 1906</u>				<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>August 8</u> , 19 <u>46</u> , to <u>August 8</u> , 19 <u>46</u> , and that I last saw him alive on <u>August 8</u> , 19 <u>46</u> .			
<b>8. AGE:</b> Years <u>46</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.				<b>Immediate cause of death</b> <u>Pulmonary Tuberculosis</u> <b>DURATION</b> <u>3 1/2 yrs.</u>			
<b>9. Birthplace</b> <u>WASHINGTON, D.C.</u> (Town, county, and state)				<b>Due to</b> _____			
<b>10. Usual occupation</b> <u>BUTCHER</u>				<b>Due to</b> _____			
<b>11. Industry or business</b>				<b>Other conditions</b> <u>Possible cardiac complications</u>			
<b>12. Name</b> <u>TIMOTHY J. BROWN</u>				(Include pregnancy within 8 months of death)			
<b>13. Birthplace</b> <u>MASS</u>				<b>Major findings of operations</b> <u>none</u>			
<b>14. Maiden name</b> <u>CATHERINE E. FLEMMING</u>				Date of op. _____			
<b>15. Birthplace</b> <u>WASHINGTON D.C.</u>				<b>Autopsy results</b> _____			
<b>16. Informant</b> <u>MRS REGINA A. BROWN</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
Address <u>8418 CUNNINGHAM DRIVE</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:			
<b>17. BURIAL</b> (Burial, cremation, or removal. Which?) Date thereof <u>AUGUST 12 1946</u> (month) (day) (year)				Accident, suicide, or homicide _____ Date of _____			
Cemetery or crematory <u>MT OLIVET CEMETERY</u>				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
Location <u>WASHINGTON, D.C.</u>				Injured at home, farm, industry, public place (where?) _____			
<b>16. Funeral director</b> <u>J. William Lee's Sons Co</u>				Means of injury _____ Injured at work? _____			
Address <u>306 - 4 ST NE. Washington, D.C.</u>				<b>23. SIGNATURE</b> <u>Louis H. Moody, Jr. M.D.</u> M.D. or other _____			
<b>19. Aug. 9, 1946</b> H. L. Janssen, Registrar				Address <u>30 D Ridge Road - Greentree, Md.</u> Date signed <u>Aug. 8, 1946</u>			



MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Marital status

8. Occupation

9. Usual residence

10. Date of birth

11. Date of admission to hospital

12. Date of discharge

13. Date of death certificate

14. Date of burial

15. Date of cremation

16. Date of interment

17. Date of funeral

18. Date of burial

19. Date of cremation

20. Date of interment

21. Date of funeral

22. Date of burial

23. Date of cremation

24. Date of interment

25. Date of funeral

26. Date of burial

27. Date of cremation

28. Date of interment

29. Date of funeral

30. Date of burial

31. Date of cremation

32. Date of interment

33. Date of funeral

34. Date of burial

35. Date of cremation

36. Date of interment

37. Date of funeral

38. Date of burial

39. Date of cremation

40. Date of interment

41. Date of funeral

42. Date of burial

43. Date of cremation

44. Date of interment

RECEIVED

AUG 10 1946

BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1240

## CERTIFICATE OF DEATH

★ 08226 231  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Pr. Geo. County  
City or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Prince Georges  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County Pr. George  
City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3229 Rhode Island Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3.(a) FULL NAME

Brown, Edward E.

### 3.(b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Marie Bakersmith

7. Birth date of deceased (mo., day, yr.) April 15, 1913 6.(c) If alive, give age..... years

8. AGE: Years 33 Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace md.  
(Town, county, and state)

10. Usual occupation Hardy man - pool room

11. Industry or business.....

12. Name Joseph M. Brown

13. Birthplace Georgia

14. Maiden name Mary L. Gorman

15. Birthplace Washington, D.C.

16. Informant Richard M. Brown

Address 1324 - Staples St. N.C.

17. Burial Date thereof Aug. 13, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Washington, D.C.

18. Funeral director Wm. J. Nalley

Address 3200 - R. I. Ave, Mt. Rainier, Md.

19. 8/12 1946 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8.10 - 1946 at 5<sup>35</sup>A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug 10 1946 and that I last saw him alive on Aug 9 1946

Immediate cause of death Removal of heart from Saphagor - (2 days after) DURATION 6 hrs

Due to Coronary artery - atherosclerosis  
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy result Same as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul O. Van Vatter  
M. D. or other

Address Washington 1980 Date signed 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 14 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on **FLM No. 1 0 6 AUG 26 1946** is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of age **MARYLAND STATE DEPARTMENT OF HEALTH**

of deceased is shown on

2411 N. Charles St., Baltimore 742

18227

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince Georges  
City or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1206-55th Ave SE Wash 190  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Brygger

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mr. Charles Brygger6.(c) If alive, give age 77 years7. Birth date of deceased (mo., day, yr.) Feb. 14, -1876-18788. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Eslöv, Sweden  
(Town, county, and state)10. Usual occupation N.W.

## 11. Industry or business

12. Name Nils Ekdahl13. Birthplace Sweden14. Maiden name Johanna15. Birthplace Sweden16. Informant Charles J. BryggerAddress 1206-55th Ave SE Wash 19017. removal Date thereof 8/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director Wm Lee's SonsAddress 300-4 st. N.E.-Wash D.C.19. 8/12 19 46 Amanda Shorney  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 46 at 8:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 19 46 to August 11 19 46 and that I last saw him alive on August 11 19 46Immediate cause of death acute coronary  
occlusion DURATION 15 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. ChesleyAddress Capitol Heights, Md. Date signed 8/12/46

RECEIVED

AUG 13 1946

BUREAU VS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore BFA

## CERTIFICATE OF DEATH

Reg. Dist. No. 237

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

Male

White

Widowed

8 (b) Name of husband or wife

(Dead)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1946

James B. Naylor

Deputy Registrar

20. DATE OF DEATH

August 6 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 27 1946, to Aug 6 1946, and that I last saw him alive on Aug. 5 1946.

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 8-6-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

08229

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County... PRINCE GEORGES

City or town... RIVERDALE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs

Hospital, institution, or street address where death occurred

4408 Queensbury Rd.

How long in hospital or institution? 5 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Prince George

City or town... Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No... 304 Montgomery Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

UNNAMED INFANT BUTLER

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 17 1946 to Aug 17 1946

and that I last saw him alive on Aug 17 1946

Immediate cause of death Summation birth 6 hrs

## DURATION

5 1/2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. H. Sweeney M.D. or other

Address 402 Main St Laurel Md Date signed 8/17/46

9. Birthplace LELAND MEMORIAL HOSPITAL  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Sterling G. Butler

13. Birthplace Ontario, Canada

14. Maiden name Winifred Waters

15. Birthplace Laurel, Maryland

16. Informant Sterling G. Butler

Address 304 Montgomery Ave. Laurel

17. Burial Date thereof Aug 18, 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ivy Hill Cemetery

Location Laurel, Maryland

18. Funeral director J. Arthur Walters

Address 254 Carroll St. Wash. D.C.

19. Aug 17 1946 James Sevey

(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 20 1945

BUREAU V &



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 18230 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Rural - Hyattsville  
 (If outside city or town limits write RURAL and give nearest town)  
 How long in above place of death? 1 year, 8 months  
 Hospital, institution, or street address where death occurred:  
Riggs Road, Route #1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Rural - Hyattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Riggs Road - Route 1  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war none

## 3. (a) FULL NAME

Mrs. Mary Jane Byrd

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Albert Theodore Byrd  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date June 19, 1872  
 deceased (mo., day, yr.)  
 8. AGE: Years 74 Months 2 Days - If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Clarksburg, West Va. ?  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business Home  
 FATHER 12. Name John Perry  
 13. Birthplace ?  
 MOTHER 14. Maiden name Jane Jessup ?  
 15. Birthplace

16. Informant Mrs. Marvie Schoech  
 Address Riggs Rd. Rt. #1, Hyattsville, Md.  
 (Burial, cremation, or removal, Which?) Burial Date thereof Aug 22, 1946  
 (month) (day) (year)  
 Cemetery or crematorium George Washington Memorial  
 Location Hyattsville, D.C.  
 13. Funeral director W.W. Chambers Co.  
 Address Washington, D.C.  
 Date Aug 20, 1946 James Levy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

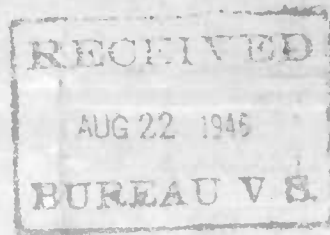
20. DATE OF DEATH August 19, 1946 at 4:06 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 1946 to August 19, 1946  
 and that I last saw her alive on August 19, 1946  
 Immediate cause of death Cerebral thrombosis DURATION 4 mo. 3 wks.  
with hemiplegia, rt. side  
 Due to Arteriosclerosis and 5 yrs.  
Hypertension 5 yrs.  
 Due to \_\_\_\_\_  
 Other conditions Chronic Myocarditis 4 mo.  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Wallace W. Mook M.D. M.D. or other \_\_\_\_\_  
 Address Jakoma Park 12 Ind. Date signed 8-19-46

Co 1770  
no molting tan



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

08231

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 10 mos., 7 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 3 yrs., 10 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 706 - 7th St. S. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

CAMPBELL, MARY ANN

## 3. (b) Social Security Number

578-28-8322

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 18, 1926  
 8. AGE: Years 20 Months 2 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name William Gilbert Campbell

13. Birthplace Washington, D. C.

14. Maiden name Edna Gardner

15. Birthplace Orange Co., Virginia

16. Informant Decedent

Address \_\_\_\_\_

17. Burial Date thereof Aug 19, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wash National Cemetery

Location Prince George Co, Md.

18. Funeral director W. W. Chambers Co.

Address 517-11-21 S. E.

19. Aug 15, 1946 Rowland S Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1946 at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8, 1942 to Aug. 15, 1946 and that I last saw him alive on Aug. 15, 1946

Immediate cause of death Tuberculous Meningitis DURATION 2 wks.

Due to Pulmonary Tuberculosis 3 yrs. 10 mo.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Finucane MD M. D. or other

Address Glenn Dale, Md. Date signed 8-15-46

RECEIVED

AUG 27 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

08232

## CERTIFICATE OF DEATH

Reg. Dist. No. 232

## 1. PLACE OF DEATH:

County... Prince George's  
 City or town... Upper Marlboro, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... Life  
 Hospital, institution, or street address where death occurred:  
 No  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Prince George's  
 City or town... Upper Marlboro (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Katherine Marbury Clagett

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed or divorced Married  
 6.(b) Name of husband or wife Hal C. B. Clagett  
 6.(c) If alive, give age 71 years  
 7. Birth date of deceased (mo., day, yr.) June 30 1884  
 8. AGE: Years 62 Months 1 Days 30 If less than one day hrs. min.

9. Birthplace Croome Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same

12. Name Fendall Marbury Jr.

13. Birthplace Piscataway, Md

14. Maiden name Lucy Clagett Berry

15. Birthplace Washington, D.C.

16. Informant Hal C. B. Clagett

Address Upper Marlboro, Md

17. Date thereof 8-31-46

(Burial, cremation, or removal, which?)

Cemetery or crematory White Buid Ground

Location Weston Prince Geo. Co. Inc

18. Funeral director Fitch Brothers

Address Upper Marlboro, Md

19. Date rec'd by registrar Aug 31 1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1946, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Aug 29 1946 and that I last saw him alive on Aug 29 1946

Immediate cause of death Congestive Heart Failure

Due to Hypertension

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James G. Darsner

Address Upper Marlboro, Md Date signed 8-30-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 2 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

## 1. PLACE OF DEATH:

County Prince George'sCity or town Fort Washington, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State --- County ---City or town Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1371 Columbia Road, N. W.  
(If rural, give LOCATION)2.(a) If veteran, name war World War I ✓

## 3. (a) FULL NAME

COMERFORD, Martin

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed6. (b) Name of husband or wife Deceased7. Birth date of deceased (mo., day, yr.) 10-23-1893

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 52 Months 9 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Massachusetts  
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

12. Name Frank Comerford13. Birthplace Ireland14. Maiden name Elizabeth Hines15. Birthplace Massachusetts16. Informant Hospital RecordsAddress Fort Washington, Maryland17. Burial Date thereof 8-14-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington, Va.18. Funeral director W. W. ChambersAddress 1400 Chapin St. N. W., Washington, D. C.19. Aug. 13 19 46 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 46 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 19 46 to August 12 19 46and that I last saw him alive on August 12 19 46Immediate cause of death Cerebral Softening DURATION 1 mo.Due to Cerebral thrombosis 2 mos.Due to Arteriosclerosis, cerebral years (?)Other conditions Tuberculosis, pulmonary, fibrocaceous type unknown  
(Include pregnancy within 3 months of death)Major findings of operations NoneAutopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work?23. SIGNATURE Chas. P. Benson, Acting CMO M. D. or otherAddress Ft. Washington, Md. Date signed 8-12-46



19  
RECEIVED

AUG 14 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32d

## CERTIFICATE OF DEATH

Reg. Dist. No. 08234 231

## 1. PLACE OF DEATH:

County Prince Georges County

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Prince George General HospitalHow long in hospital or institution? 12 days

## 3. (a) FULL NAME

Converse, Mrs. Elsie

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mr. Henry J. Converse

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Oct. 26, 1886

8. AGE:

Years

Months

Days

If less than one day

59

hrs.

min.

9. Birthplace

Mass.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Jonathan Lewis

13. Birthplace

Mass

MOTHER

14. Maiden name

Jessie Harris

15. Birthplace

Mass.

16. Informant

Mr. Kenny Converse

Address

BeltsvilleMd.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Meadow View

Location

Amherst New Hampshire

18. Funeral director

F. J. Asch Sons

Address

Nyattsville, Ind.

19.

8/8  
(Date rec'd by registrar)46Amanda Daunez

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Pr. Geo. Co.

City or town

Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

8-5

19

46

at

6:10

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1

19

43

to

Aug 5

19

46

and that I last saw him alive on

Aug 4

19

46

Immediate cause of death

DURATION

Due to

Cerebral Aneurysm  
Spontaneous Rupture

Due to

Hypertensive Heart  
Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Col. J. W. H.

M. D. or other

Address

Hagerstown Md.

Date signed

8/8/46

RECEIVED  
AUG 9 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08235

242

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Fort Washington, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... North Carolina County.....  
 City or town..... Durham  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 703 W. Markham Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... World War I ✓

## 3. (a) FULL NAME

DAVIS, Thomas B.

## 3. (b) Social Security Number

242-09-0730

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... Julia C. Davis6. (c) If alive, give age..... Unk...... years

## 7. Birth date of deceased (mo., day, yr.)

November 1, 1892

## 8. AGE:

Years

Months

Days

If less than one day

53922

.....hrs. ....min.

9. Birthplace..... Franklin County, North Carolina  
(Town, county, and state)10. Usual occupation..... Salesman

## 11. Industry or business

FATHER

12. Name..... Venerable Davis13. Birthplace..... Franklin County, North Carolina

MOTHER

14. Maiden name..... Rosa Ball15. Birthplace..... Franklin County, North Carolina16. Informant..... Hospital RecordsAddress..... Fort Washington, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 8-26-46  
(month) (day) (year)Cemetery or crematory..... Arlington National CemeteryLocation..... Arlington Va.18. Funeral director..... W.W. Chambers Co.Address..... 1400 Chapin N.W.19. 8/23-..... 19 46  
(Date rec'd by registrar)Carrin Campbell  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... August 23..... 19 46 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 21..... 19 46 to August 23..... 19 46and that I last saw him..... in..... alive on..... August 23..... 19 46

Immediate cause of death.....

Aneurysm, aortic, saccular

DURATION

4 yrs.Due to..... Syphilis, tertiaryyrs(?)Due to.....  
 Other conditions..... Pleurisy, chronic, fibrous,  
bilateral  
 (Include pregnancy within 3 months of death)yrs(?)Major findings of operations..... None

..... Date of op. ....

Autopsy results..... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Injured at work?.....

23. SIGNATURE..... Charles P. Benson M.D.Address..... Fort Washington, Md. Date signed..... 8-23-46

RECEIVED  
AUG 27 1946  
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08236

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince George's  
 City or town... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mos., 29 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 2 mos., 29 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2610 - Georgia Ave. N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... — ✓

## 3. (a) FULL NAME

DODSON, WALTER GRESHAM

## 3. (b) Social Security Number

577-30-3863

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife...  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) November 1, 1900  
 8. AGE: Years 45 Months 9 Days 13 If less than one day  
 hrs. min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business

12. Name Henry Dodson  
 13. Birthplace Washington, D. C.  
 14. Maiden name Ida West  
 15. Birthplace Maryland

16. Informant Decedent

Address  
 17. Removal Date thereof Aug 14, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Lincoln Memorial Cem.  
 Location to Washington, D.C.

18. Funeral director John T. Rhines & Co  
 Address 901 - 3rd St. S.W.

19. Aug 14 19 46 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46 at 7:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 16 19 46 to Aug 14 19 46  
 and that I last saw him alive on Aug 14 19 46

Immediate cause of death  
Pulmonary Tuberculosis

## DURATION

4 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD M. D. or other

Address Glenn Dale, Md. Date signed 8-14-46

RECEIVED  
AUG 27 1946  
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 7 mos., 8 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 3 yrs., 7 mos., 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Sisters of Poor Home  
3rd and H Sts. N.E.  
 (If rural, give LOCATION) E.  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

MICHAEL FRANCIS DORSEY

## 3. (b) Social Security Number

-

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed6. (b) Name of husband or wife Mary Dorsey (dec.)

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 4, 18728. AGE: Years 74 Months 4 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ireland  
(Town, county, and state)10. Usual occupation None

11. Industry or business \_\_\_\_\_

FATHER 12. Name Patrick Dorsey13. Birthplace IrelandMOTHER 14. Maiden name Bridget Cross15. Birthplace Ireland16. Informant Decedent

Address \_\_\_\_\_

17. removal Date thereof Aug. 21, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington, D.C.18. Funeral director Albert J. AsheAddress 641 H. St., N.E., Washington, D.C.19. Aug. 21, 1946 R. Rowland S. Philips  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1946 at 12:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13, 1943 to Aug. 21, 1946 and that I last saw him alive on Aug. 20, 1946Immediate cause of death Pulmonary Tuberculosis DURATION 18 yrsDue to Other conditions:  
Arterio-sclerotic heart disease 16 yrsDue to Chronic lymphatic leukemia 9 yrs

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Finucane MD

M. D. or other

Address Glenn Dale, Md. Date signed 8/21/46

RECEIVED

P 3 1946

ADVIS

RECEIVED

SEP 3 1946

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

## CERTIFICATE OF DEATH

08238

Reg. Dist. No. 342

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Chase Hill  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

5210 - P Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Chase Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5210 - P Street

(If rural, give LOCATION)

2.(c) If veteran, name war

## 3. (a) FULL NAME

Rebecca Slade Eberle

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Frank H. Eberle

## 8. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

November 11, 1864

## 8. AGE:

Years 84 Months 8 Days 28  
 If less than one day hrs. min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

Benjamin Franklin

## 12. Name

England

## 13. Birthplace

England

## 14. Maiden name

England

## 15. Birthplace

England

## 16. Informant

Frank H. Eberle

## Address

5210 - P Street, Prince George's Co., Md.

## 17. Burial

Burial

## Date thereof

Aug 17, 1946  
(month) (day) (year)

## Cemetery or crematory

Wash. National

## Location

Pr. Geo. Co., Md.

## 18. Funeral director

W. W. Chambers Co.

## Address

517-11-46, Wash., D.C.

## 19. (Date rec'd by registrar)

19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 46, at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

## Immediate cause of death

Acute Congestive Heart Failure

## Due to

Cardiovascular renal disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

Reput Medical Examiner

## 23. SIGNATURE

James J. Fox  
M. D. or other

## Address

ForesholtonDate signed 8-9-46

RECEIVED  
AUG 10 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Chantilly  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

St. Elizabeth's HospitalHow long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgesCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. Shamrock St  
(If rural, give LOCATION) Shamrock Ave2. (a) If veteran, name war WW

## 3. (a) FULL NAME

Allen A Edelin

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Ethel M. Edelin

7. Birth date of deceased (mo., day, yr.)

May 19 1893

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

532hrs.min.

## 9. Birthplace

D.C.  
(Town, county, and state)

## 10. Usual occupation

Veterinarian

## 11. Industry or business

## FATHER

## 12. Name

Richard Edelin

## 13. Birthplace

## MOTHER

## 14. Maiden name

Allen

## 15. Birthplace

Se.

## 16. Informant

Ethel M. EdelinAddress 4236 Shamrock Ave. Balto. Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

8/13/46  
(month) (day) (year)

Cemetery or crematory

Congressional Cemetery

Location

Wash. D.C.

## 18. Funeral director

W. W. Chambers Co

Address

Riversdale Md

## 19.

(Date read by registrar)

19.

8/1146Amanda Downey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 19 46 at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 7 19 46 to Aug 10 19 46and that I last saw him alive on Aug 9 19 46

Immediate cause of death

Myocardial Infarction

DURATION

Due to

acute coronary

Due to

myocardial

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. W. Chambers  
N. 13, 15, 17, 19, 21, 23, 25, 27, 29, 31, 33, 35, 37, 39, 41, 43, 45, 47, 49, 51, 53, 55, 57, 59, 61, 63, 65, 67, 69, 71, 73, 75, 77, 79, 81, 83, 85, 87, 89, 91, 93, 95, 97, 99, 101, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 123, 125, 127, 129, 131, 133, 135, 137, 139, 141, 143, 145, 147, 149, 151, 153, 155, 157, 159, 161, 163, 165, 167, 169, 171, 173, 175, 177, 179, 181, 183, 185, 187, 189, 191, 193, 195, 197, 199, 201, 203, 205, 207, 209, 211, 213, 215, 217, 219, 221, 223, 225, 227, 229, 231, 233, 235, 237, 239, 241, 243, 245, 247, 249, 251, 253, 255, 257, 259, 261, 263, 265, 267, 269, 271, 273, 275, 277, 279, 281, 283, 285, 287, 289, 291, 293, 295, 297, 299, 301, 303, 305, 307, 309, 311, 313, 315, 317, 319, 321, 323, 325, 327, 329, 331, 333, 335, 337, 339, 341, 343, 345, 347, 349, 351, 353, 355, 357, 359, 361, 363, 365, 367, 369, 371, 373, 375, 377, 379, 381, 383, 385, 387, 389, 391, 393, 395, 397, 399, 401, 403, 405, 407, 409, 411, 413, 415, 417, 419, 421, 423, 425, 427, 429, 431, 433, 435, 437, 439, 441, 443, 445, 447, 449, 451, 453, 455, 457, 459, 461, 463, 465, 467, 469, 471, 473, 475, 477, 479, 481, 483, 485, 487, 489, 491, 493, 495, 497, 499, 501, 503, 505, 507, 509, 511, 513, 515, 517, 519, 521, 523, 525, 527, 529, 531, 533, 535, 537, 539, 541, 543, 545, 547, 549, 551, 553, 555, 557, 559, 561, 563, 565, 567, 569, 571, 573, 575, 577, 579, 581, 583, 585, 587, 589, 591, 593, 595, 597, 599, 601, 603, 605, 607, 609, 611, 613, 615, 617, 619, 621, 623, 625, 627, 629, 631, 633, 635, 637, 639, 641, 643, 645, 647, 649, 651, 653, 655, 657, 659, 661, 663, 665, 667, 669, 671, 673, 675, 677, 679, 681, 683, 685, 687, 689, 691, 693, 695, 697, 699, 701, 703, 705, 707, 709, 711, 713, 715, 717, 719, 721, 723, 725, 727, 729, 731, 733, 735, 737, 739, 741, 743, 745, 747, 749, 751, 753, 755, 757, 759, 761, 763, 765, 767, 769, 771, 773, 775, 777, 779, 781, 783, 785, 787, 789, 791, 793, 795, 797, 799, 801, 803, 805, 807, 809, 811, 813, 815, 817, 819, 821, 823, 825, 827, 829, 831, 833, 835, 837, 839, 841, 843, 845, 847, 849, 851, 853, 855, 857, 859, 861, 863, 865, 867, 869, 871, 873, 875, 877, 879, 881, 883, 885, 887, 889, 891, 893, 895, 897, 899, 901, 903, 905, 907, 909, 911, 913, 915, 917, 919, 921, 923, 925, 927, 929, 931, 933, 935, 937, 939, 941, 943, 945, 947, 949, 951, 953, 955, 957, 959, 961, 963, 965, 967, 969, 971, 973, 975, 977, 979, 981, 983, 985, 987, 989, 991, 993, 995, 997, 999, 1001, 1003, 1005, 1007, 1009, 1011, 1013, 1015, 1017, 1019, 1021, 1023, 1025, 1027, 1029, 1031, 1033, 1035, 1037, 1039, 1041, 1043, 1045, 1047, 1049, 1051, 1053, 1055, 1057, 1059, 1061, 1063, 1065, 1067, 1069, 1071, 1073, 1075, 1077, 1079, 1081, 1083, 1085, 1087, 1089, 1091, 1093, 1095, 1097, 1099, 1101, 1103, 1105, 1107, 1109, 1111, 1113, 1115, 1117, 1119, 1121, 1123, 1125, 1127, 1129, 1131, 1133, 1135, 1137, 1139, 1141, 1143, 1145, 1147, 1149, 1151, 1153, 1155, 1157, 1159, 1161, 1163, 1165, 1167, 1169, 1171, 1173, 1175, 1177, 1179, 1181, 1183, 1185, 1187, 1189, 1191, 1193, 1195, 1197, 1199, 1201, 1203, 1205, 1207, 1209, 1211, 1213, 1215, 1217, 1219, 1221, 1223, 1225, 1227, 1229, 1231, 1233, 1235, 1237, 1239, 1241, 1243, 1245, 1247, 1249, 1251, 1253, 1255, 1257, 1259, 1261, 1263, 1265, 1267, 1269, 1271, 1273, 1275, 1277, 1279, 1281, 1283, 1285, 1287, 1289, 1291, 1293, 1295, 1297, 1299, 1301, 1303, 1305, 1307, 1309, 1311, 1313, 1315, 1317, 1319, 1321, 1323, 1325, 1327, 1329, 1331, 1333, 1335, 1337, 1339, 1341, 1343, 1345, 1347, 1349, 1351, 1353, 1355, 1357, 1359, 1361, 1363, 1365, 1367, 1369, 1371, 1373, 1375, 1377, 1379, 1381, 1383, 1385, 1387, 1389, 1391, 1393, 1395, 1397, 1399, 1401, 1403, 1405, 1407, 1409, 1411, 1413, 1415, 1417, 1419, 1421, 1423, 1425, 1427, 1429, 1431, 1433, 1435, 1437, 1439, 1441, 1443, 1445, 1447, 1449, 1451, 1453, 1455, 1457, 1459, 1461, 1463, 1465, 1467, 1469, 1471, 1473, 1475, 1477, 1479, 1481, 1483, 1485, 1487, 1489, 1491, 1493, 1495, 1497, 1499, 1501, 1503, 1505, 1507, 1509, 1511, 1513, 1515, 1517, 1519, 1521, 1523, 1525, 1527, 1529, 1531, 1533, 1535, 1537, 1539, 1541, 1543, 1545, 1547, 1549, 1551, 1553, 1555, 1557, 1559, 1561, 1563, 1565, 1567, 1569, 1571, 1573, 1575, 1577, 1579, 1581, 1583, 1585, 1587, 1589, 1591, 1593, 1595, 1597, 1599, 1601, 1603, 1605, 1607, 1609, 1611, 1613, 1615, 1617, 1619, 1621, 1623, 1625, 1627, 1629, 1631, 1633, 1635, 1637, 1639, 1641, 1643, 1645, 1647, 1649, 1651, 1653, 1655, 1657, 1659, 1661, 1663, 1665, 1667, 1669, 1671, 1673, 1675, 1677, 1679, 1681, 1683, 1685, 1687, 1689, 1691, 1693, 1695, 1697, 1699, 1701, 1703, 1705, 1707, 1709, 1711, 1713, 1715, 1717, 1719, 1721, 1723, 1725, 1727, 1729, 1731, 1733, 1735, 1737, 1739, 1741, 1743, 1745, 1747, 1749, 1751, 1753, 1755, 1757, 1759, 1761, 1763, 1765, 1767, 1769, 1771, 1773, 1775, 1777, 1779, 1781, 1783, 1785, 1787, 1789, 1791, 1793, 1795, 1797, 1799, 1801, 1803, 1805, 1807, 1809, 1811, 1813, 1815, 1817, 1819, 1821, 1823, 1825, 1827, 1829, 1831, 1833, 1835, 1837, 1839, 1841, 1843, 1845, 1847, 1849, 1851, 1853, 1855, 1857, 1859, 1861, 1863, 1865, 1867, 1869, 1871, 1873, 1875, 1877, 1879, 1881, 1883, 1885, 1887, 1889, 1891, 1893, 1895, 1897, 1899, 1901, 1903, 1905, 1907, 1909, 1911, 1913, 1915, 1917, 1919, 1921, 1923, 1925, 1927, 1929, 1931, 1933, 1935, 1937, 1939, 1941, 1943, 1945, 1947, 1949, 1951, 1953, 1955, 1957, 1959, 1961, 1963, 1965, 1967, 1969, 1971, 1973, 1975, 1977, 1979, 1981, 1983, 1985, 1987, 1989, 1991, 1993, 1995, 1997, 1999, 2001, 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019, 2021, 2023, 2025, 2027, 2029, 2031, 2033, 2035, 2037, 2039, 2041, 2043, 2045, 2047, 2049, 2051, 2053, 2055, 2057, 2059, 2061, 2063, 2065, 2067, 2069, 2071, 2073, 2075, 2077, 2079, 2081, 2083, 2085, 2087, 2089, 2091, 2093, 2095, 2097, 2099, 2101, 2103, 2105, 2107, 2109, 2111, 2113, 2115, 2117, 2119, 2121, 2123, 2125, 2127, 2129, 2131, 2133, 2135, 2137, 2139, 2141, 2143, 2145, 2147, 2149, 2151, 2153, 2155, 2157, 2159, 2161, 2163, 2165, 2167, 2169, 2171, 2173, 2175, 2177, 2179, 2181, 2183, 2185, 2187, 2189, 2191, 2193, 2195, 2197, 2199, 2201, 2203, 2205, 2207, 2209, 2211, 2213, 2215, 2217, 2219, 2221, 2223, 2225, 2227, 2229, 2231, 2233, 2235, 2237, 2239, 2241, 2243, 2245, 2247, 2249, 2251, 2253, 2255, 2257, 2259, 2261, 2263, 2265, 2267, 2269, 2271, 2273, 2275, 2277, 2279, 2281, 2283, 2285, 2287, 2289, 2291, 2293, 2295, 2297, 2299, 2301, 2303, 2305, 2307, 2309, 2311, 2313, 2315, 2317, 2319, 2321, 2323, 2325, 2327, 2329, 2331, 2333, 2335, 2337, 2339, 2341, 2343, 2345, 2347, 2349, 2351, 2353, 2355, 2357, 2359, 2361, 2363, 2365, 2367, 2369, 2371, 2373, 2375, 2377, 2379, 2381, 2383, 2385, 2387, 2389, 2391, 2393, 2395, 2397, 2399, 2401, 2403, 2405, 2407, 2409, 2411, 2413, 2415, 2417, 2419, 2421, 2423, 2425, 2427, 2429, 2431, 2433, 2435, 2437, 2439, 2441, 2443, 2445, 2447, 2449, 2451, 2453, 2455, 2457, 2459, 2461, 2463, 2465, 2467, 2469, 2471, 2473, 2475, 2477, 2479, 2481, 2483, 2485, 2487, 2489, 2491, 2493, 2495, 2497, 2499, 2501, 2503, 2505, 2507, 2509, 2511, 2513, 2515, 2517, 2519, 2521, 2523, 2525, 2527, 2529, 2531, 2533, 2535, 2537, 2539, 2541, 2543, 2545, 2547, 2549, 2551, 2553, 2555, 2557, 2559, 2561, 2563, 2565, 2567, 2569, 2571, 2573, 2575, 2577, 2579, 2581, 2583, 2585, 2587, 2589, 2591, 2593, 2595, 2597, 2599, 2601, 2603, 2605, 2607, 2609, 2611, 2613, 2615, 2617, 2619, 2621, 2623, 2625, 2627, 2629, 2631, 2633, 2635, 2637, 2639, 2641, 2643, 2645, 2647, 2649, 2651, 2653, 2655, 2657, 2659, 2661, 2663, 2665, 2667, 2669, 2671, 2673, 2675, 2677, 2679, 2681, 2683, 2685, 2687, 2689, 2691, 2693, 2695, 2697, 2699, 2701, 2703, 2705, 2707, 2709, 2711, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727, 2729, 2731, 2733, 2735, 2737, 2739, 2741, 2743, 2745, 2747, 2749, 2751, 2753, 2755, 2757, 2759, 2761, 2763, 2765, 2767, 2769, 2771, 2773, 2775, 2777, 2779, 2781, 2783, 2785, 2787, 2789, 2791, 2793, 2795, 2797, 2799, 2801, 2803, 2805, 2807, 2809, 2811, 2813, 2815, 2817, 2819, 2821, 2823, 2825, 2827, 2829, 2831, 2833, 2835, 2837, 2839, 2841, 2843, 2845, 2847, 2849, 2851, 2853, 2855, 2857, 2859, 2861, 2863, 2865, 2867, 2869, 2871, 2873, 2875, 2877, 2879, 2881, 2883, 2885, 2887, 2889, 2891, 2893, 2895, 2897, 2899, 2901, 2903, 2905, 2907, 2909, 2911, 2913, 2915, 2917, 2919, 2921, 2923, 2925, 2927, 2929, 2931, 2933,

RECEIVED  
AUG 14 1946  
BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges

City or town Sandover Hills  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Sandover Hills  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207-71st Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

ROYAL BURDICK EMBREE

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Ellen Chapman Embree

6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1873

8. AGE: 72 Years Months Days If less than one day hrs. min.

9. Birthplace Westfield N.Y.  
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Paper industry

12. Name Edward E. Embree

13. Birthplace N.Y.

14. Maiden name Matilda Pearson

15. Birthplace N.Y.

16. Informant Mrs. Earl Gibbs

Address 4207-71st Ave. Sandover Hills Md.

17. Cremation Date thereof Aug 29 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory J. William Heis Sons Co.

Location Washington D.C.

18. Funeral director J. W. Heis Sons Co.

Address 300-42nd St. N.E. Washington D.C.

19. 8/28 1946 Amanda Dorney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 1946 to 27 Aug 1946.

and that I last saw him alive on 26 Aug 1946.

Immediate cause of death Nephritis, chronic glomerular. DURATION 1 year

Due to 4

Due to

Other conditions arteriosclerosis, generalized 3 years  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel J. N. Sugar M.D. or other

Address 4300 Kaywood Drive Date signed 28 Aug 46  
Mt. Rainier, Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

AUG 29 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of **MARYLAND STATE DEPARTMENT OF HEALTH**  
 year of birth of deceased is shown **2411 N. Charles St., Baltimore**  
**FILM No. I O 6 SEP 5 1946** **CERTIFICATE OF DEATH**

08241  
 Reg. Dist. No. **239**

**1. PLACE OF DEATH:**  
 County... **Prince George**  
 City or town... **Laurel**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **3 YR.; 6 M.; 7 D**  
 Hospital, institution, or street address where death occurred:  
**Laurel Sanatorium**  
 How long in hospital or institution? **3 YR.; 6 M.; 7 D**

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State... **Maryland** County...  
 City or town... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **500 2321 W. North Ave**  
 (If rural, give LOCATION)

**3. (a) FULL NAME** **Mary Ann Glynn** **3. (b) Social Security Number**

**4. Sex** **Female** **5. Color or race** **White** **6. (a) Single, married, widowed, or divorced** **Widow**  
**6. (b) Name of husband or wife** **John Henry Glynn**  
**8. AGE:** **84** Years **6** Months **2** Days **1862**  
 (If less than one day) **hrs. min.**

**9. Birthplace** **Ireland**  
 (Town, county, and state)

**10. Usual occupation** **House wife**

**11. Industry or business**

**12. Name** **Cornelia Fara**

**13. Birthplace** **Ireland**

**14. Maiden name** **Margaret Doyle**

**15. Birthplace** **Ireland**

**16. Informant** **Sanatorium Records**

**Address** **Laurel Sanatorium Laurel, Md**

**17. Burial** **8-23-1946**  
 (Burial, cremation, or removal, which?) **8-23-1946**  
 (month) (day) (year)

**Cemetery or crematory** **Cathedral**

**Location** **Baltimore Md**

**18. Funeral director** **Glynn & Glynn**

**Address** **1426 Light St**

**19. 8/22/46** **26** **Dr. H. H. Hedrick**  
 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** **August 20** **1946** at **5:56 P M**

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from **February 13** **1946** to **Feb. 20** **1946**  
 and that I last saw him alive on **February 20** **1946**

**Immediate cause of death** **arterio-sclerosis**  
**Entero**

**Due to** **Senility**

**Due to**

**Other conditions**

(Include pregnancy within 3 months of death)

**Major findings of operations**

**Autopsy results**

**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of

**Where did injury occur?** (City or town) (County) (State)

**Injured at home, farm, industry, public place (where?)**

**Means of injury** **Injured at work?**

**23. SIGNATURE** **John L. Wetherill** **M. D. or other**  
**Address** **Laurel Sanatorium** **Date signed** **8/20/46**



1830

1830

BRITISH MUSEUM, LONDON

1830

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★08242 mfs  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Prince Georges  
City or town N. Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs.  
Hospital, institution, or street address where death occurred 3918 Allison Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town N. Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3918 Allison St.  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Lucy Galloway

### 3. (b) Social Security Number

4. Sex F 5. Color or race W.C. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Herbert G. Galloway  
(deceased) 6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) June 8, 1876

8. AGE: Years 70 Months 2 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Own home

12. Name John H. Thomas

13. Birthplace Maryland

14. Maiden name Annelle Randall

15. Birthplace Maryland

16. Informant Mrs. Gertrude Jones

Address 3918 Allison St. N. Brentwood

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 22, 1946  
(month) (day) (year)

Cemetery or crematory Lincoln Memorial

Location Suitland Md.

18. Funeral director F. Sascha, sons

Address Hyattsville Md.

19. Aug 24 1946 James Seery  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August, 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1, 1946 to Aug. 19, 1946  
and that I last saw her alive on Aug. 19, 1946

Immediate cause of death Myocarditis  
pericarditis (hemopericardium)  
Due to Nephritis acute

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William H. Spiller M.D.

M. D. or other \_\_\_\_\_

Address Brentwood, Md. Date signed 8-19-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 22 1946

BURFAT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B7a)

## CERTIFICATE OF DEATH

08243

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Cottage City MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

MARY B. GORDON

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Cottage City MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Robert L. Gordon

8. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

FEB. 1 1874

## 8. AGE:

Years

Months

Days

If less than one day

72

6

hrs.

min.

## 9. Birthplace

Scotland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## f2. Name

John B. McDonald

## f3. Birthplace

Scotland

MOTHER

## f4. Maiden name

Annie Banks

## f5. Birthplace

Scotland

## 16. Informant

William R. McDonaldAddress 3717 42ave. Cottage City MD.17. removal

(Burial, cremation, or removal. Which?)

Date thereof

8 - 2 - 1946  
(month) (day) (year)

Cemetery or crematory

Location

## 18. Funeral director

The S.H. Hiner Co

Address

2901 14th St19. Aug 21

(Date rec'd by Registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1946 at 430 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16 1945 to Aug 2 1946  
that I last saw h.e. alive on Aug 2 1946Immediate cause of death Arteriosclerotic  
Heart and Kidney disease  
Hypertensive Heart disease

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. J. H. Hager M.D. or otherAddress 3717-38th Ave Date signed

CERTIFICATE OF DEATH

RECEIVED

AUG 5 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

08244

Reg. Dist. No.

231

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Alexandria  
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

1302-51st Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Alexandria  
(if outside city or town limits, write RURAL and give nearest town)Street No. 1302-51st Street  
(if rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jean Gorham

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

August 16, 1941

8. AGE:

Years

Months

Days

If less than one day

5-7

hrs.

min.

9. Birthplace

Alexandria, Md.  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address 1302-51st Street17. Buried  
(Burial, cremation, or removal. Which?)Date thereof Aug 26, 1946  
(month) (day) (year)Cemetery or crematory Parque, Wash. D.C.

Location

18. Funeral director

Address F. J. Gans's Sons  
Bladensburg, Md.19. 8/26 19 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 19 46 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

Shock

DURATION

Due to

Universal third degree

Due to

burns of the body

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Aug 23, 1946Where did injury occur? Alexandria P. M. (City or town) County (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury House burned down (How?)Deputy Medical Examiner

23. SIGNATURE

James D. Jones M. D. or otherAddress Forest Hill, Md. Date signed 8-23-46

RECEIVED

AUG 27 1946

BUREAU V. A.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186

08245

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges

City or town Leonardwood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1302-51st Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Leonardwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1302-51st  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Leroy Wm. Gorham Jr

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Leonwood Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1946 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h alive on 19

Immediate cause of death

Shock

Due to

Universal third degree  
burns of the body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-23-46

Where did injury occur? Leonardwood P.G. Co. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury House burned to ground by fire

Deputy medical examiner

23. SIGNATURE

Address Freshwater Md Date signed 8-23-46

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 27 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

FILEM No. I 06 SEP 5 1946

# CERTIFICATE OF DEATH

Reg. Dist. No. 08246 231

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Leeswood  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
1302 - 51st Ave  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Leeswood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1302 - 51st Ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war

## 3. (a) FULL NAME

Ruth Gorham

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 22, 1943 6. (c) If alive, give age..... years

8. AGE: Years 2 Months 2 Days 10 If less than one day 1 hrs. min.

9. Birthplace Leeswood Md  
(Town, county, and state)

10. Usual occupation none

## 11. Industry or business

12. Name Terry Gorham

13. Birthplace District of Columbia

14. Maiden name Lillian Gordon

15. Birthplace District of Columbia

16. Informant Louise Corner

Address 1302 - 51st Street

17. Burial Date thereof Aug 26 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bayne

Location Wash. D.C.

18. Funeral director J. Barba Sons

Address Bladensburg, Md

19. 8/26 19 46 Armand H. Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 19 46 at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and that I last saw him ..... alive on ..... 19.....

Immediate cause of death shock

Due to Universal third degree burn of the body  
Due to.....  
Other conditions.....

Major findings of operations.....

Antemortem results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-23-46

Where did injury occur? Leeswood P.S. Md  
(City or town) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury House burned Thrown at work?

23. SIGNATURE James J. J. J. M.D. or other

Address Frostville Md Date signed 8-23-46

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AUG 27 1946  
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08247

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George'sCity or town (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mos., 6 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 6 mos., 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 640 Eye St. S. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ERBIE N. GRAHAM

## 3. (b) Social Security Number

212-16-5013

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married (separated)</u>	
6. (b) Name of husband or wife <u>Katherine Graham</u>			
7. Birth date of deceased (mo., day, yr.) <u>January 6, 1917</u>			
8. AGE: Years <u>29</u>	Months <u>7</u>	Days <u>19</u>	If less than one day .....hrs. ....min.

9. Birthplace Westagusta, Virginia  
(Town, county, and state)10. Usual occupation Truck Driver

11. Industry or business

12. Name Jake Graham13. Birthplace West Virginia14. Maiden name Grace Altizer15. Birthplace Virginia16. Informant Decedent

Address

17. Burial Date thereof Aug. 26, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChurchvilleLocation Virginia18. Funeral director W. W. Chambers CoAddress 517-11-st. S. E.19. Aug. 25, 46 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 46 at 1:55 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19, 1946 to Aug. 25, 46and that I last saw him alive on Aug. 25, 1946Immediate cause of death Tuberculous Meningitis

## DURATION

16 da.Due to Pulmonary Tuberculosis3 yr 1 mo.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinucane MD  
M. D. or otherAddress Glenn Dale, Md Date signed 8/25/46

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SEP 3 1946

**BUREAU V S**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-0)

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Cherry Hill  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Death on arrival  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Wixom  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2408 57th Place  
(If rural, give LOCATION)2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Ronald Theodore Halzinger

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Marathy Halzinger6. (c) If alive, give age 30 years

## 7. Birth date of

deceased (mo., day, yr.)

Sept 23, 1898

## 8. AGE:

Years

Months

Days

If less than one day

47

hrs.

min.

## 9. Birthplace

minn.

(Town, county, and state)

## 10. Usual occupation

cab driver

## 11. Industry or business

MOTHER FATHER

## 12. Name

John Halzinger

## 13. Birthplace

Germany

## 14. Maiden name

Sarah Ford

## 15. Birthplace

minn.

## 16. Informant

Marathy Halzinger

## Address

2408 57th Place, Wixom, Mich

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Tr. Lutheran Cemetery

## Location

Was h. v.c.

## 18. Funeral director

W.W. Chavels & Co

## Address

Rivendale Mich

## 19.

8/19

13

46 Amanda Deeney

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Aug 17

19

at

5-40 P

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h

alive on

19

## Immediate cause of death

## DURATION

Acute congestive heart failure  
Cardiovascular renal disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

## Injured at work?

deputy medical examiner

## 23. SIGNATURE

James D. Ford

M.D. or other

Address

Freestalls Mich

Date signed

8/17/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



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BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08249

243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 9 mos., 13 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 2 yrs., 9 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 Logan Circle N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HILL BERTHA

## 3. (b) Social Security Number

-

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 22, 1916  
 8. AGE: Years 30 Months 6 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greenwood, South Carolina  
 (Town, county, and state)  
 10. Usual occupation General Housekeeping  
 11. Industry or business \_\_\_\_\_  
 12. Name Walter Hill  
 13. Birthplace Greenwood, South Carolina  
 14. Maiden name Katherine Romans  
 15. Birthplace Greenwood, South Carolina

16. Informant Decedent  
 Address \_\_\_\_\_  
 17. Removal Date thereof Aug 14, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location to Washington D.C.  
Taft H. Williams  
 18. Funeral director Taft H. Williams  
 Address 1702 12th St N W  
Aug 11, 46 Rowland S. Phillips  
 (Date rec'd by registrar) (19) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1946, at 1 p. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/29 1946 to 8/11 1946  
 and that I last saw him alive on 8/11 1946  
 Immediate cause of death pulmonary tuberculosis DURATION 3 years  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinecone M.D. M. D. or other \_\_\_\_\_  
 Address Glenn Dale, Md. Date signed 8/11/46

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AUG 27 1946  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(742)

08250

## CERTIFICATE OF DEATH

Reg. Diat. No. 245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Bradbury Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mi  
 Hospital, institution, or street address where death occurred:  
5123-T Street SE  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Bradbury Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5123-T Street SE  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

James Salomon Ivey

## 3. (b) Social Security Number

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 19, 1903

8. AGE: 42 Years Months Days If less than one day hrs. min.

9. Birthplace Geneva, Ala.  
 (Town, county, and state)

10. Usual occupation Garage Business

11. Industry or business

12. Name William J. Ivey

13. Birthplace Houston, Tex.

14. Maiden name Sarah F. Kirkland

15. Birthplace Houston, Tex.

16. Informant A. G. Ivey

Address Houston, Ala.

17. Transportation Date thereof Aug 4, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dodman, Ala.

Location

18. Funeral director W. R. Pumphrey

Address Bethesda, Md.

19. Aug 4, 46 James Ivey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4, 1946 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 18

Immediate cause of death Coronary Occlusion DURATION

Due to Coronary Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner

James D. Ivey M. D. or other

Address Freshtown Date signed 8-4-46

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AUG 16 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

2411 N. Charles St., Baltimore

08251

# CERTIFICATE OF DEATH

Reg. Dist. No. 243

FILM No. 106 SEP 5 1946

1. PLACE OF DEATH:  
County... Prince George's  
City or town... (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mos., 2 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 3 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... D. C. County...  
City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1831- 19th St. N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name War -

3. (a) FULL NAME

THEODORE R. JENNINGS

3. (b) Social Security Number

224-16-8772

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife -  
7. Birth date of deceased (mo., day, yr.) August 19, 1920  
8. AGE: Years 25 Months 26-11 Days -29 If less than one day - hrs. min.

9. Birthplace Charlottesville, Virginia  
(Town, county, and state)  
10. Usual occupation Kitchen Employee  
11. Industry or business  
12. Name Carl Jennings  
13. Birthplace Charlotte, North Carolina  
14. Maiden name Susie Moore  
15. Birthplace Charlotte, North Carolina  
16. Informant Decadent

Address  
17. Removal Date thereof Aug. 19, 1946  
(Burial, cremation, or removal. Which?)  
Cemetery or crematory  
Location to Washington, D.C.  
18. Funeral director Malvern Schee  
Address 424 R. St. N.W.  
19. Aug. 17, 1946 Rowland S. Philips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 17 1946 at 12:30 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 15 1946 to AUG. 17 1946  
and that I last saw him alive on AUG. 17 1946

Immediate cause of death PULMONARY TUBERCULOSIS  
DURATION 3 mos.  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD  
M. D. or other  
Address Glenn Dale, Md. Date signed 8/17/46

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AUG 27 1945  
BUREAU 7 B



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0825205 240

1. PLACE OF DEATH:  
 County.....PRINCE GEORGE'S COUNTY  
 City or town.....CEDARVILLE, MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....9 wks.  
 Hospital, institution, or street address where death occurred:  
 CEDARVILLE, MD  
 How long in hospital or institution?.....NONE

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....md County.....Pr Geo Co  
 City or town.....Cedarville, md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 DAVID MONROE JONE-S

3. (b) Social Security Number

4. Sex.....M 5. Color or race.....W 6. (a) Single, married, widowed, or divorced.....M

6. (b) Name of husband or wife.....VIRGIE IRENE JONES

7. Birth date of deceased (mo., day, yr.).....JAN 13, 1864 6. (c) If alive, give age.....12 years

8. AGE: Years.....82 Months.....7 Days.....4 If less than one day.....hrs.....min.

9. Birthplace.....Wood Center, Fayette Co Iowa  
 (Town, county, and state)

10. Usual occupation.....Painter

11. Industry or business

12. Name.....Alexander Jones

13. Birthplace.....Lova

14. Maiden name.....Ann Corke

15. Birthplace.....Lova

16. Informant.....Mrs W m Cutler

Address.....Brandywine, md

17. Burial Date thereon.....Aug 20, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Emmanuel Cemetery

Location.....Horsehead, md

18. Funeral director.....Huntt & Ryan

Address.....Waldorf, md

Aug 19 1946 M S. Moore

Aug 21 1946 J H. Billingsley

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....AUGUST 18 1946 at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to AUG 18 1946 and that I last saw him alive on AUGUST 16 1946

Immediate cause of death.....RESPIRATORY FAILURE

Due to.....CEREBRAL HEMORRHAGE

Due to.....CARDIOVASCULAR DISEASE - HYPERTENSION

Other conditions.....Y ARTERIOSCLEROSIS

(Include pregnancy within 8 months of death)

Major findings of operations.....NONE

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Alfred R. Lapin

Address.....Aghasso, Md M. D. Other

Date signed.....Aug 19 1946

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AUG 26 1946  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

## CERTIFICATE OF DEATH

Reg. Dist. No. 08253 239

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

305 Montgomery Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. 325 Montgomery Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Lloyd Kaiser

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Irene Kaiser6.(c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) Sept. 15, 194 18958. AGE: Years 50 Months 10 Days 24 If less than one day  
.....hrs. ....min.9. Birthplace Prince Georges Co., Maryland  
(Town, county, and state)10. Usual occupation Undertaker

11. Industry or business

12. Name Wm. E. Kaiser13. Birthplace Maryland14. Maiden name Rosa Mae Kaiser Crandell15. Birthplace Maryland16. Informant Mrs. Lloyd KaiserAddress 325 Montgomery Ave., Laurel17. Burial Date thereof Aug. 12, '46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemetaryLocation Baltimore Md18. Funeral director R. SelbyAddress Laurel, Maryland19. August 10, 1946 Chas E. Wachter  
(Date recd. by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 19 46, at 9 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 14 19 37, to 8 9 19 46and that I last saw him alive on Aug 9 19 46Immediate cause of death Coronary ThrombosisDue to My hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D.  
M. D. or otherAddress Laurel Date signed 8/11/46

Injured at home, farm, industry, public place (where?)

Injured at work?

RECEIVED

AUG 16 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16020

## CERTIFICATE OF DEATH

Reg. Dist. No.

18254  
231

## 1. PLACE OF DEATH:

County Prince George  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Prince George General HospitalHow long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince GeoCity or town Branchville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Betty Jean King

## 3. (b) Social Security Number

4. Sex female 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Aug. 18 - 1946 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cheverly, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Hoggee King13. Birthplace B14. Maiden name maiden White15. Birthplace —

16. Informant \_\_\_\_\_

Address \_\_\_\_\_

17. Burial Date thereof 8/24/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Scitland18. Funeral director W.W. Chubb CoAddress Prinnydale Rd19. 8/24 46 Amanda Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23- 19 46, at 10:40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-21- 19 46, to 8-23- 19 46and that I last saw him alive on 8-22- 19 46Immediate cause of death Brain hemorrhage

## DURATION

Due to injury incident to both

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Leo W. DufaultAddress 2725 Pa. Ave. SE Date signed 8/23/46Wash. 20, D.C.

MARGIN RESERVED FOR BINDING

VS A15

9-45-1354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 26 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08255

243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 23 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 709 - Mass. Avenue N. E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

GAIL E. LEWIS

## 3. (b) Social Security Number

233-12-5994

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife -  
 6. (c) If alive, give age 5 years  
 7. Birth date of deceased (mo., day, yr.) April 25, 1920  
 8. AGE: Years 26 Months 4 Days 6 It less than one day hrs. min.

9. Birthplace Glasgow, West Virginia  
 (Town, county, and state)  
 10. Usual occupation Truck Driver  
 11. Industry or business Bergmann's Laundry  
 FATHER 12. Name James A. Lewis  
 13. Birthplace Glasgow, West Virginia  
 MOTHER 14. Maiden name Myrtle E. Hennings  
 15. Birthplace Glasgow, West Virginia

16. Informant Decedent  
 Address Removal  
 17. (Burial, cremation, or removal. Which?) Removal Date thereof Aug 31, 1946  
 (month) (day) (year)  
 Cemetery or crematory to Washington, D. C.  
 Location Wm. J. Spall  
 18. Funeral director 522-8-11 St. S. E. Wash. D. C.  
 Address Aug 31, 1946 Rowland Philip  
 19. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1946 at 12:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8, 1946 to Aug 31, 1946  
 and that I last saw him alive on Aug 30, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 1 1/2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD M. D. or otherAddress Glenn Dale Md Date signed 8/31/46



RECEIVED  
SEP 7 1946  
BUREAU V. 1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

08256  
Reg. Dist. No. 342

### 1. PLACE OF DEATH:

County Pr. George  
City or town Capitol Heights Md  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 412 49<sup>a</sup> Ave  
Stay in hospital or inst. (yrs., or mos., or days)  
Stay in this community (yrs., or mos., or days) 18 years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Pr. Geo. Co.  
City or town Capitol Heights Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 412 49<sup>a</sup> Ave  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Edward Joseph Link

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6 (b) Name of ~~husband~~ wife Elsie M Link  
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 10 1898

8. AGE: Years 48 Months 2 Days 7 If less than one day  
hrs. min.

9. Birthplace Washington D.C  
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Suit Printing Office

FATHER 12. Name Frank Joseph Link

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Susie R Kinder

15. Birthplace Cloppers Maryland

16. Informant Theresa Link  
Address 416 - 49<sup>a</sup> Ave Capitol Hts Md

17. Burial Date thereof 8-20-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Pr. Geo. Co.

18. Funeral director J. Wm. Lees Sons Co

Address 300 - 4th Street N.E.

19. Aug. 19 19 46 Carrie Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 46, at 1:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46, to Aug 17 19 46, and that I last saw him alive on Aug 16 19 46.

Immediate cause of death Carcinoma of recto-sigmoid junction

Due to

Due to

Other conditions metastatic carcinoma of liver and intestines  
(Include pregnancy within 8 months of death)

Major findings:

Of operations Apr 24 1946 - Exploratory Laparotomy showed above findings No section to show type

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. Smit Pritchard MD  
6906 Pritchard Road SE M. D. or other  
Address Wash. 19, D.C. Date signed Aug 17 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 20 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**  
of deceased is shown on

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08257 245  
Reg. Dist. No.

FILM No. **I 07 SEP 17 1946**

## 1. PLACE OF DEATH:

County **Prince George's**  
City or town **Hyattsville**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **about 150 years**  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Prince George's**  
City or town **Hyattsville Md**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **6000 Baltimore Ave**  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

**Emma V. Lyon**

## 3. (b) Social Security Number

4. Sex **F** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **M.**

6. (b) Name of husband or wife **Wallace C. Lyon**

7. Birth date of deceased (mo., day, yr.) **Oct. 1, 1871** 6. (c) If alive, give age **75** years

8. AGE: Years **74** Months **75** Days **75** If less than one day **hrs.** min.

9. Birthplace **Kentucky**  
(Town, county, and state)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Edward Dietzman**

13. Birthplace **Ky**

14. Maiden name **Catherine Dietzman**

15. Birthplace **Ky**

16. Informant **Helen L. Donaldson**

Address **6000 Baltimore Ave**

17. **buried** Date thereof **Aug. 28, 1946**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location **2901-14 St. W. Wash. D.C.**

18. Funeral director **The S. F. Jones Co**

Address **2901 14 St NW B.B.**

19. **Aug 28** 19 **46** **Journey Seay**  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 28** 19 **46** at **8 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 1** 19 **45** to **August 27** 19 **46**  
and that I last saw her alive on **August 27** 19 **46**

Immediate cause of death **Cerebral Hemorrhage**

Due to **Arterio sclerosis**

Due to **None**

Other conditions **None**

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE **George W. Patterson**  
M. D. or other

Address **4313 Baltimore St.** Date signed **Aug 28 46**  
**Hyattsville, Md.**

RECEIVED

AUG 29 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08258  
231

### 1. PLACE OF DEATH:

County Prince George's

City or town Chesley, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General Hospital  
Upper Marlboro, Md.

How long in hospital or institution?

### 3. (a) FULL NAME

Magruder, Caleb C

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.)

1866

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Caleb Magruder

13. Birthplace

Maryland

MOTHER

14. Maiden name

Elizabeth Hall

15. Birthplace

Virginia

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8 28 46  
(month) (day) (year)

Cemetery or crematory

Home cemetery

Location

Near Beltspring, Md.

18. Funeral director

Address

Ritchie Bros  
Upper Marlboro, Md.

19.

(Date rec'd by registrar)

8/27 1946

Emanda Doremus  
Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27

19. 46

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 May

19. 46

to

27 Aug

19. 46

and that I last saw him alive on

25 May 46

19. 46

Immediate cause of death

Cardiac decompensation

DURATION

1 1/2 hours

Due to

arteriosclerotic cardiac  
vascular disease

Unknown

Due to

Other conditions

Pulmonary tuberculosis  
chronic ulcerative  
(Include pregnancy within 3 months of death)

3 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R B Lasser

M. D. or other

Address

Upper Marlboro, Md.

Date signed

27 Aug 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 29 1946  
BUREAU OF



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08259

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:  
County Prince George's  
City or town (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs., 10 mos.  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 2 years, 10 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 203 - F. St. N. W.  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_ ✓

3. (a) FULL NAME

RUPERT J. MCCORMACK

3. (b) Social Security Number

508-16-2565

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married (separated)  
6. (b) Name of husband or wife Kate McCormack  
7. Birth date of deceased (mo., day, yr.) August 8, 1891 6. (c) If alive, give age 57 years  
8. AGE: Years 55 Months 0 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dillon, South Carolina  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name James A. McCormack  
13. Birthplace Dillon, South Carolina

14. Maiden name Virginia Legette  
15. Birthplace Dillon, South Carolina

16. Informant Decedent

Address

17. Burial Date thereof Aug. 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Ashepole Cemetery  
Location Robertson Co., N.C.

18. Funeral director Wastler Funeral Home  
Address 301 E. Capitol St. Wash. D.C.

19. Aug. 26, 1946 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1946 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26, 43 to Aug 26, 46  
and that I last saw him alive on Aug 25, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 7 yrs 11 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Finucane MD M. D. or other \_\_\_\_\_

Address Glenn Dale, Md. Date signed 8/24/46

MARGIN RESERVED FOR BINDING

VS A15 10-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 3 1946

BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

## CERTIFICATE OF DEATH

Reg. Dist. No. 082043

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Mitchelville B.F.V.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months  
 Hospital, institution, or street address where death occurred:  
~~~~~  
 How long in hospital or institution? ~~~~~

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Mitchelville B.F.V.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ~~~~~  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ~~~~~

## 3. (a) FULL NAME

Wallace Anthony Mc Kenzie Jr.

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 8.(b) Name of husband or wife Single  
 7. Birth date of deceased (mo., day, yr.) March 25 1946 6.(c) If alive, give age ~~~~~ years  
 8. AGE: Years 5 Months 3 Days ~~~~~ If less than one day  
 hrs. ~~~~~ min. ~~~~~

8. Birthplace Mitchelville B.F.V.  
 (Town, county, and state)

10. Usual occupation Infant

## 11. Industry or business

MOTHER FATHER  
 12. Name Wallace A. McKenzie  
 13. Birthplace Upper Marlboro, Md  
 14. Maiden name Lillian Irene Brady  
 15. Birthplace Bowie, Md

16. Informant Wallace A. McKenzie  
 Address Mitchelville, Md

17. Buried Date thereof Aug 30 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Family  
 Location Mitchelville and  
Clarence Foreacre

18. Funeral director ~~~~~  
 Address Mitchelville and

19. Aug 29 19 46 Louise H. Beach  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 46 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug 21 19 46 to Aug 28 19 46  
 and that I last saw him alive on Aug 26 19 46

Immediate cause of death Whooping Cough  
 Due to ~~~~~

Due to ~~~~~

Other conditions Bronchial Pneumonia  
 (Include pregnancy within 3 months of death)

Major findings of operations none  
 Date of op. ~~~~~

Autopsy results no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ~~~~~ Date of ~~~~~

Where did injury occur? ~~~~~  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ~~~~~

Means of injury ~~~~~ Injured at work? ~~~~~

23. SIGNATURE James P. Parker  
 Address Upper Marlboro Md M. D. or other  
 Date signed 8-28-46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RECORDED

SEP 5 1946

BUREAU V E

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 842

## CERTIFICATE OF DEATH

08261

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 months 14 days  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Geo.  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Marine's Home for Defective Children  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Janice B. Merrill

### 3. (b) Social Security Number

—

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 41 1946

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

17

hrs. min.

9. Birthplace

Washington D.C.  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

St. John J. Merrill

13. Birthplace

Pa

14. Maiden name

Annie Brice

15. Birthplace

Portland Maine

16. Informant

St. John J. Merrill

Address

Washington D.C.

17.

Cremation

Date thereof

Aug 26, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Hill Cemetery

Location

Springfield Md

18. Funeral director

F. Gusch's sons

Address

Hyattsville Md

19.

8/26

19

46

Amanda Downey

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

August 21

19

46, at 10:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 12, 1946, to Aug 21, 1946

and that I last saw him alive on August 21, 1946

Immediate cause of death

Malnutrition

DURATION

Due to

Mongolian Idiocy

17 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, M.D.

M. D. or other

Address

Chesver, Md

Date signed 8-23-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 27 1946  
BUREAU VS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13/50)

## CERTIFICATE OF DEATH

08262

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Collington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Collington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Daniel Hamilton Owens

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Mary Mollie Owens  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 Months Days If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Robert Owens

13. Birthplace Maryland

14. Maiden name Susan Greenwell

15. Birthplace Maryland

16. Informant Estelle Heeling

Address Collington Md

17. Burial Date thereof Aug 19 46  
(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Acadensis

Location Bowie Md

18. Funeral director Martin Fladung

Address Bowie Md

19. August 19 46 Mrs. J.W. Yingling  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 46 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19...

and that I last saw him alive on 19...

Immediate cause of death Congestive heart failure

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Bond M. D. Forester

Address Forestville Md Date signed 8-17-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
AUG 27 1946  
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month, 5 days

Hospital, institution, or street address where death occurred:

410 Ethan Allen Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mount Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3605 Perry Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Harry Piggott

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

## 6.(c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

83

hrs.

min.

## 9. Birthplace

Detroit Michigan  
(Town, county, and state)

## 10. Usual occupation

Pressman

## 11. Industry or business

Gov't Bureau Engraving & Printing

## FATHER

## 12. Name

Harry Piggott

## 13. Birthplace

Detroit, Michigan

## MOTHER

## 14. Maiden name

—

## 15. Birthplace

—

## 16. Informant

Harold Edward Piggott

## Address

851 Riggs Ave., Detroit, Michigan

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

Aug 17, 1946  
(month) (day) (year)

## Cemetery or crematory

Fort Lincoln Cemetery

## Location

3201-Bladenburg Rd. Md.

## 18. Funeral director

Wm. J. Walker

## Address

3200-A.I. Ave. Mt. Rainier, Md.

## 19.

(Date rec'd by registrar)

19

46Amanda Kurey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946, at 3:35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 11, 1946, to Aug. 14, 1946and that I last saw him alive on August 14, 1946

Immediate cause of death

Acute indigestion

## DURATION

1 dayDue to chronic MyocarditisyearsDue to Arteriosclerosis and HypertensionyearsOther conditions ulceration rt. leg50 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wallace H. Mook M.D.

M. D. or other

Address

Takoma Park Md.Date signed 8-15-46

RECEIVED

106 19 1945

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08264

Reg. Dist. No. 224

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Oxon Hill Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Capitol Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5124 - Wheeler Rd S.E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

SAMUEL P. PUMPHREY

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Helen Elizabeth  
 7. Birth date of deceased (mo., day, yr.) Feb - 6<sup>th</sup> 1872 6. (c) If alive, give age. \_\_\_\_\_ years  
 8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Prince Georges Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation Trucker

## 11. Industry or business

12. Name James W. Pumphrey  
 13. Birthplace Md  
 14. Maiden name Sarah J  
 15. Birthplace Md

16. Informant Mrs Helen Elizabeth Pumphrey  
 Address 5124 - Wheeler Rd S.E.

17. Burial Date thereof August 20 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St Barnabas  
 Location Oxon Hill Md

18. Funeral director Thomas F. Murray  
 Address 2007 - Nichols Ave S.E.

19. Aug 19 1946 Howard J. Weese  
 (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1946 to Aug 17 1946 and that I last saw him alive on Aug 16 1946

Immediate cause of death Acute Coronary Thrombosis and myocardial infarction

Due to General Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 9 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. SIGNATURE Frederick W. Weese

Address Washington 1946 Date signed Aug 17 1946

RECEIVED  
AUG 22 1946  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0826243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 6 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 30 Dingman Place N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

ELIZABETH C. REED

## 3. (b) Social Security Number

-

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) March 23, 1931 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 15 Months 5 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Joseph Reed  
 13. Birthplace Maryland

MOTHER 14. Maiden name Alberta ?  
 15. Birthplace Maryland

16. Informant Decedent  
 Address \_\_\_\_\_

17. Removal Date thereof Aug. 26, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem.  
to Washington, D.C.  
 Location \_\_\_\_\_

18. Funeral director Ruth Wabney  
 Address 442 Mt. NW

19. Aug. 25, 1946 T. Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1946 at 11:30 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 29, 1946 to Aug. 25, 1946  
 and that I last saw her alive on Aug. 25, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 1 1/2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinckney M.D. M. D. or other

Address Glenn Dale, Md. Date signed 8/25/46

RECEIVED

SEP 3 1946

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B2

## CERTIFICATE OF DEATH

08266

Reg. Dist. No. 243.

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1223 Potomac St. N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HELEN D REID

## 3. (b) Social Security Number

?

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife George Reid

7. Birth date of deceased (mo., day, yr.) September 2, 1908  
 6. (c) If alive, give age 41 years

8. AGE: Years 37 Months 11 Days 27 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation Maid

11. Industry or business \_\_\_\_\_

FATHER 12. Name Richard Bell  
 13. Birthplace Chevy Chase, Maryland

MOTHER 14. Maiden name Katie Johnson  
 15. Birthplace Chevy Chase, Maryland

16. Informant Decedent  
 Address \_\_\_\_\_

17. Removal Date thereof Aug. 30, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location to Washington, D. C.

18. Funeral director Ambrose Boyd  
 Address 1238 20th St N W

19. Aug. 29, 46 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1946 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1946 to Aug 29, 1946  
 and that I last saw her alive on August 29, 1946

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary Tuberculosis 4 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Lee Prineas MD  
 M. D. or other \_\_\_\_\_

Address Glenn Dale, Md. Date signed 8/29/46

RECEIVED

SEP 18 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 139

## CERTIFICATE OF DEATH

08267

Reg. Diat. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Riversdale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Silver Memorial HospitalHow long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Riversdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4700 Somerset Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Allen Kenneth Richey

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

newborn

## 6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

Aug 5, 1946

## 8. AGE:

Years

Months

Days

If less than one day

4

hrs. min.

## 9. Birthplace.....

Riversdale, Md.  
(Town, county, and state)

## 10. Usual occupation.....

## 11. Industry or business.....

## FATHER

## 12. Name

Edwin R. Richey

## 13. Birthplace

Ellen Rock, Penna

## MOTHER

## 14. Maiden name

Edgill M. Weaver

## 15. Birthplace

Seitzland, Penna.

## 18. Informant

Address

Edwin R. Richey (father)  
4700 Somerset Rd. Riversdale Md

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 10, 1946  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Colman Manor Md

## 18. Funeral director

Address

F. Sacchi, Rome  
Hyatlerille Md

## 19. Date rec'd by registrar

Aug 10 1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 46, at 4:45 A..M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 5 19 46, to Aug. 9 19 46.and that I last saw him alive on Aug. 9 19 46.

Immediate cause of death

Prematurity

DURATION

4 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Manner of injury

Injured at work?

23. SIGNATURE

L. W. Mullen MD  
M. D. or otherAddress Riversdale, Md. Date signed 8-9-46

*Carroll*

6-1-

RECEIVED  
AUG 10 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age  
shown on Film G106 9/4/46 dm

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 906

## CERTIFICATE OF DEATH

08268  
Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24 hrs - 32 min  
Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Prince Georges  
City or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Rifenbark, Mr. Warren

### 3. (b) Social Security Number

4. Sex male 5. Color or race W. 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Mrs. Lillian Rifenbark  
7. Birth date of deceased (mo., day, yr.) Feb. 26, 1883 8. (c) If alive, give age 47 years  
8. AGE: 63 Years 66 Months 5 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/46 19 46 at 1052 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 41 to \_\_\_\_\_ 19 46  
and that I last saw h.c.m. alive on Aug 20 AM 19 46  
Immediate cause of death Pericardial hemorrhage DURATION \_\_\_\_\_

Due to Cerebral Thrombosis + rupture of heart.  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Pericardial hemorrhage  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. R. L. H. P.  
M. D. or other \_\_\_\_\_  
Address H. G. H. L. L. L. Date signed 8-20-46

9. Birthplace Wisc.  
(Town, county, and state)  
10. Usual occupation Horticulturist  
11. Industry or business Bells Station Md  
12. Name Edgar Rifenbark  
13. Birthplace Wisc.  
14. Maiden name Mary Rothman  
15. Birthplace Wisc.  
16. Informant Mrs. Pauline Walker  
Address 5002 - 78th Ave West Lehigh  
17. Burial Date thereof Aug 23, 1946  
(Burial, cremation, or removal) Which? (month) (day) (year)  
Cemetery or crematory Fort Lincoln  
Location Colmar Manor Md  
18. Funeral director F. Gasche son  
Address Hyattsville Md  
19. 8/21/46 Amanda Downey  
(Date rec'd by registrar) Registrar

RECEIVED  
AUG 22 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George'sCity or town (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mos., 16 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 2 mos., 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 500 Virginia Avenue S. E.  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

ROBERTS MARTHA

## 3. (b) Social Security Number

-

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

Colored

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 16, 19138. AGE: Years Months Days If less than one day  
32 11 23 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace LaPlata, Maryland  
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

FATHER 12. Name Seymour Roberts13. Birthplace Charlow, MarylandMOTHER 14. Maiden name Elizabeth Lloyd15. Birthplace Newport, Maryland16. Informant Decedent

Address \_\_\_\_\_

17. removal Date thereof Aug 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington, D. C.18. Funeral director George A. Better SonsAddress 1203 Wall St. S.E. Washington D. C.19. Aug 8, 46 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-46 1946, at 6:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-23 1946, to 8-8 1946and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 1946Immediate cause of death PULMONARY  
TUBERCULOSIS FAR ADVANCED DURATION 4 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinicane MD M. D. or otherAddress Glenn Dale, Md. Date signed 8/8/46



AUG 16 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08270 <sup>231</sup>  
245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Bladensburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
4408-46th Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Bladensburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4408-46th Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Louise White Ross

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Harvey Matthew White B.(c) If alive, give age 44 years  
 7. Birth date of deceased (mo., day, yr.) Sept 1, 1900  
 8. AGE: Years 45 Mon/ys 11 Days 27 If less than one day hrs. min.

9. Birthplace Washington DC  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name George Thornton13. Birthplace Virginia14. Maiden name Betty Elizabeth Green15. Birthplace Howard County, Maryland16. Informant Edna May DeckerAddress 4408-46th Street17. Removal Date thereof Aug 27 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Removal to R.C.

Location

18. Funeral director W. Ernest Garmis Co.Address 1432 4th St. N.W. Wash. D.C.19. Aug 28 19 46 John Seery  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946 at 9:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Acute congestive heart failure  
 Due to Cardiovascular renal disease

Due to  
 Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

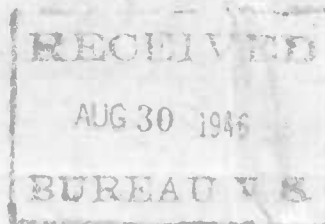
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James J. Ford M.D. or other  
 Address Frederick Md Date signed 8-27-46

Mrs. Severe  
4309 Garragut St.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100)

## CERTIFICATE OF DEATH

08271

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Cheverly  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? approx 1 hr.  
 Hospital, institution, or street address where death occurred:  
Prince George's General Hosp. Cheverly, Md.  
 How long in hospital or institution? approx 1 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Baby Boy Ryan

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MWSingle

## 6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day  
0 0 0 1 hrs. min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Robert H. Ryan

13. Birthplace.....

14. Maiden name Cecilia Thompson15. Birthplace DC.16. Informant Robert H. RyanAddress 6250 46<sup>th</sup> place, Bethesda, Md.17. Cremation Date thereof 9/6/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prince George's General HospitalLocation Cheverly, Md.18. Funeral director A. H. Besley, SuperintendentAddress same19. 9/7 46 Amanda Dawsey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 46 at 2:55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8-25-46 19....., to..... 19.....  
 and that I last saw him 129 alive on 8-25-46 19.....

Immediate cause of death..... DURATION

AsphyxiaDue to Profound cord

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE John P. Clem M.D. M. D. or otherAddress Hyaltonville Md Date signed 8-25-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 10 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

## CERTIFICATE OF DEATH

Reg. Dist. No. 1827242

## 1. PLACE OF DEATH:

County Pr. George  
 City or town Ritchie  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 MonthsHospital, institution, or street address where death occurred:  
6906 Ritchie Rd SE. Wash 19, D.C.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6701 Ritchie Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Minnie Iola Ryan

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband William S. Ryan

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 6 1870

8. AGE: Years 75 Months 10 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Croome Pr Golo Md  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name John Mathias Kaldenbach13. Birthplace Pa.14. Maiden name Mary Jane Hyde15. Birthplace Cederville Maryland16. Informant Mrs Mildred RitchieAddress 6906 Ritchie Rd SE Wash 19, D.C.17. Burial Date thereof 8 17 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forestville IndLocation Forestville Ind18. Funeral director Ritchie BrosAddress Upper Marlboro Ind19. 8-16-46 Thos S Guffitt  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46 at 1:30 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to Aug 14 19 46and that I last saw him alive on Aug 14 19 46

Immediate cause of death carcinoma of larynx  
 DURATION 15 Months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions metastatic carcinoma of nasopharynx 12 months

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Suit Ritchie MD M. D. or otherAddress 6906 Ritchie Rd SE Washington 19, D.C. Date signed Aug 14 1946

RECEIVED

AUG 20 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 08273 245

## 1. PLACE OF DEATH:

County Prince George's

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

6616 - Poplar Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6616 - Poplar Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Andrew George Sanford

## 3. (b) Social Security Number

578-32-6923

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Georgia Sanford

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1893

8. AGE: Years 53 Months 5 Days 7

If less than one day hrs. min.

9. Birthplace Washington DC  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business was telephoned U.S. Gov

12. Name Andrew J. Sanford

13. Birthplace Washington DC

14. Maiden name Anne M. Juppier

15. Birthplace Washington DC

16. Informant Ruby M. de Fazio

Address 2124 - Eye Street, NW, Wash. D.C.

17. Burial, cremation, or removal. Which? Burial

Date thereof 8-21-46  
(month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va

18. Funeral director Joseph Gawlusson

Address 1756 Pa. Ave. N.W. Wash. D.C.

19. Aug 21, 1946

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21, 1946, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death acute congestive heart failure

Due to cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Boyle

Address Forestville, Md. Date signed 8-21-46

RECEIVED

AUG 26 1946

BURLAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08274 245

## 1. PLACE OF DEATH:

County... PRINCE GEORGE

City or town... MT RAINIER  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 YRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... PRINCE GEORGE

City or town... MT RAINIER  
(If outside city or town limits, write RURAL and give nearest town)Street No. MD 21 36 ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARY ELIZABETH SAUR

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

HENRY A SAUR

## 7. Birth date of

deceased (mo., day, yr.) JULY 31, 1859

## 8. AGE:

Years 87

Months 0

Days 15

If less than one day

hrs. min.

## 9. Birthplace

BROOKLYN, NEW YORK  
(Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

## FATHER

## 12. Name

GEORGE SCHENBERGER

## 13. Birthplace

GERMANY

## MOTHER

## 14. Maiden name

UNKNOWN

## 15. Birthplace

GERMANY

## 16. Informant

MR HENRY A SAUR

Address MD 21 36 ST MT. RAINIER, MD.

## 17.

BURIAL

## Date thereof

AUG. 17, 1946

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

PROSPECT HILL

## Location

WASHINGTON, D.C.

## 18. Funeral director

W.W. CHAMBERS CO.

## Address

1400 CHAPIN ST. N.W. WASH. D.C.

## 19.

Aug 15 1946  
(Date rec'd by registrar)

James Sevey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1, 1946, to August 15, 1946

and that I last saw her alive on August 14, 1946

Immediate cause of death

Arteriosclerotic  
CARDIOVASCULAR RENAL DISEASE

DURATION

1 year

Due to

Generalized arteriosclerosis

1 yr.

Due to

Other conditions

Decubitus ulcer

2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

151062 AR. LAVINE, M. D. or other  
Address Ab. Ranne Date signed 8/15/46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
AUG 17 1946  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

## CERTIFICATE OF DEATH

Reg. Dist. No.

08275

232

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Clinton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:  
Hangerfield Home

How long in hospital or institution:

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Clinton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Hangerfield Home  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Jack Joseph Scandone

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) February 1, 1940 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 6 Months 5 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation: none

11. Industry or business:

12. Name Paul Scandone13. Birthplace Italy14. Maiden name Mary Carlin15. Birthplace Washington D.C.16. Informant husband ScandoneAddress Clinton, Md.17. Burial Date thereof Aug 5 - 46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. OliverLocation Washington D.C.18. Funeral director W. P. Piche BrothersAddress 4010 Marlboro Rd.19. Aug 3rd 19 46 Registrar R. B. Smith

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 19 46 at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death: Exhaustion, Typhoid DURATIONDue to Generalized lymphadenomaDue to sarcoma

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op. \_\_\_\_\_

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Dr. P. Smith M. D. or other \_\_\_\_\_Address Forestville, Md. Date signed 8-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 5 1946  
BUREAU V D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

243

## 1. PLACE OF DEATH:

County Prince George'sCity or town Glenn Dale - RURAL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months 2 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 2 months, 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1225- Kings Ct., N.W.  
(If rural, give LOCATION)2. (a) If veteran, name war ☒

## 3. (a) FULL NAME

SEWELL, MARY E.

## 3. (b) Social Security Number

577-26-2069

## 4. Sex

female

## 5. Color or race

col.

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Thomas Sewell

## 7. Birth date of

deceased (mo., day, yr.)

August 10, 1915

## 6. (c) If alive, give age

56 years

## 8. AGE:

Years

30

Months

11

Days

26

If less than one day

.....hrs. ....min.

## 9. Birthplace

Washington, D. C.

(Town, county, and state)

## 10. Usual occupation

maid in hotel

## 11. Industry or business

FATHER

## 12. Name

Washington B. Hill

## 13. Birthplace

? Virginia

MOTHER

## 14. Maiden name

Alice Owens

## 15. Birthplace

?, Maryland

## 16. Informant

deceased

## Address

## 17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

## 18. Funeral director

Address

## 19.

(Date rec'd by registrar)

8/5/46Rowland Phillips

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1946 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3, 1946 to Aug 5, 1946  
and that I last saw her alive on Aug 4, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1.3 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane, MD  
Address Glenn Dale, Md. Date signed 8-5-46



RECEIVED

AUG 9 1946

BUREAU V S.

Handwritten: 358402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 242

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH *Pr. George*County *Annapolis*City or town *Annapolis*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Pr. George*City or town *Annapolis*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *Annapolis Road*

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

*Sally Mae Sharrick*

## 3. (b) Social Security Number

4. Sex *Female*5. Color or race *White*6. (a) Single, married, widowed, or divorced *-*

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *June 2nd 1946*8. AGE: Years *2* Months *18* Days *18* It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace *Baltimore, Md.*  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name *Mr. Sharrick*13. Birthplace *Anna*14. Maiden name *Melba Kiel*15. Birthplace *Russia*16. Informant *Mr. Sharrick*Address *3457 PK. N. Gt. Ave*17. (Burial, cremation, or removal. Which) *Burial*Date thereof *8-20-46*Cemetery or crematory *Rosedale*Location *John J. Maloney, Inc.*18. Funeral director *1439 E. Balto. St*Address *8/21 46*19. (Date recd by registrar) *8/21 46*Registrar *A. W. Hedrick*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 20* 19 *46* at *7:40 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 11* 19 *46* to *Aug 20* 19 *46*and that I last saw her alive on *Aug 9* 19 *46*Immediate cause of death *malnutrition*Due to *monogham & chow*Due to *3 mo. 19 d.*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John J. Maloney, M.D.*Address *Cherry - Md*Date signed *8-20-46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

## CERTIFICATE OF DEATH

08278

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges County  
 City or town Capitol Heights, Cheverly  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Pr. Geo. Cty.  
 City or town Cap. Hgts.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 803 58th Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sherman, Mrs. Mary

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced  
 6. (b) Name of husband or wife Raymond E. Sherman  
 7. Birth date of deceased (mo., day, yr.) 1901 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 45 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ohio  
 (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business \_\_\_\_\_

12. Name Norner Weintzelsman

13. Birthplace Ohio

14. Maiden name Emma Miller

15. Birthplace Pa.

16. Informant Hospital Records

Address \_\_\_\_\_

17. Burial Date thereof 8-8-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Lee Tonia Opion

18. Funeral director W. W. Chambers Co.

Address 517-11th St. S.E.

19. 8/7 46 Amanda Spurney  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7-46 19 235 at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/7 19 46 to 8/7 19 46

and that I last saw her alive on 8/7 19 46

Immediate cause of death Acute gangrenous Pancreatitis DURATION 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

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RECEIVED  
AUG 8 1946  
BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 200-3

## CERTIFICATE OF DEATH

08279  
Reg. Dist. No. 242

### 1. PLACE OF DEATH

County Pr. Geo.  
City or town Farmington Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 hr  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Pr. Geo.  
City or town Farmington Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 506 62nd Ave NE  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Baby Simms

### 3. (b) Social Security Number

4. Sex F 5. Color of race C 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age 1 hr years

7. Birth date of deceased (mo., day, yr.) Aug 7 1946

8. AGE: Years Months Days If less than one day 1 hrs. 30 min.

9. Birthplace 506 62nd Ave, NE  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Oliver Simms

13. Birthplace Pittsburgh Va

14. Maiden name Beth Alexander

15. Birthplace Goffney, S.C.

16. Informant Anna Alexander

Address 506 62nd Ave NE

17. Burial Date thereof Aug. 9. 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location DC

18. Funeral director Mabran + Soley

Address 4445 Dean Ave NE

19. Aug. 8 19 46 Carrie Campbell  
(Date registered by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 19 46, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Baby had been dead 14 hrs and that I last saw him alive on 19 46

Immediate cause of death Unknown  
(Baby had been dead 14 hrs when I first saw it.)

Due to it  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE James E. Beale MD  
M. D. or other  
Address 1209 Que St NE Date signed 8/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 10 1946  
BUREAU T.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08280 243

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 yrs., 7 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution?..... 2 yrs., 7 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1214 - 5th St. N. W.  
 (If rural, give LOCATION) ✓  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

MARIE LAWRENCE SMITH

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife..... -

7. Birth date of deceased (mo., day, yr.) December 5, 1928  
 6. (c) If alive, give age..... years

8. AGE: Years 17 Months 8 Days 8 If less than one day hrs. min.

9. Birthplace Charlotte, North Carolina  
 (Town, county, and state)

10. Usual occupation School Girl

## 11. Industry or business

FATHER 12. Name Charles Smith  
 13. Birthplace North Carolina  
 MOTHER 14. Maiden name Sara Truesdale  
 15. Birthplace North Carolina

16. Informant Decedent

Address

17. removal (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1946  
 (month) (day) (year)

Cemetery or crematory Washington, D. C.  
 Location R. H. Dabney

18. Funeral director R. H. Dabney  
 Address 442 M St. N. W., Washington, D. C.

19. Aug. 13, 1946 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13<sup>th</sup> 1946 at 12<sup>50</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17<sup>th</sup> 1943 to Aug. 13<sup>th</sup> 1946 and that I last saw him alive on Aug. 12<sup>th</sup> 1946

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 2 yrs 7 mos

Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD  
 M. D. or other

Address Glenn Dale, Md. Date signed 8/13/46



RECEIVED

AUG 27 1946

BUREAU V B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George'sCity or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Prince George's General

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George'sCity or town Capitol Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. 401-39 Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ISABELLE - LUCY - STOMMEL -

## 3. (b) Social Security Number

4. Sex M5. Color or race Wh6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Walter Stommel7. Birth date of deceased (mo., day, yr.) Jul 27/90

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

hrs

min.

9. Birthplace Wash. D.C.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Frank C. Manning13. Birthplace DC14. Maiden name Shummers15. Birthplace DC16. Informant Walter C. StommelAddress 401-39 Ave Apt 40517. (Burial, cremation, or removal. Which?) BurialDate thereof 8/27/96  
(month) (day) (year)Cemetery or crematory Cedar HillLocation Capitol Hill18. Funeral director Chambers CoAddress 577-11 St SE19. 8/19 1996  
(Date rec'd by registrar)Amenda Dooney  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1996

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15 1992 to Aug 19 1996and that I last saw her alive on August 19 1996Immediate cause of death Cerebral Hemorrhage

DURATION

28 hrsDue to Generalized arteriosclerosis3 yrsdiabetic mellitus3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE William Brannin

M. D. on duty

Address Capitol Hill, MD Date signed 8/25/96

MARGIN RESERVED FOR BINDING

VS A15 9-45-1-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 22 1946

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

08282 342  
Reg. Dist. No.

1. PLACE OF DEATH:  
County Prince George  
City or town Capitol Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years  
Hospital, institution, or street address where death occurred:  
336 Southern Avenue  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Prince George  
City or town Capitol Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 336 Southern Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Grady Monroe Stuart 3. (b) Social Security Number 578-01-8907

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Mary Ellen Stuart  
6.(c) If alive, give age 51 years  
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1889  
8. AGE: Years 56 Months Days If less than one day hrs. min.

9. Birthplace Cullman Alabama  
(Town, county, and state)  
10. Usual occupation Iron worker  
11. Industry or business Construction  
12. Name Jasper B. Stuart  
13. Birthplace Ala.  
14. Maiden name Rosa E. Gay  
15. Birthplace Ala.

16. Informant Mary Ellen Stuart  
Address 336 Southern Ave. Capitol Heights Md.  
17. Cremation Date thereof 8-27-46  
(Burial, cremation, or other, which?) (month) (day) (year)  
Cemetery or crematory Forest Lawn  
Location Capitol Heights Md.

18. Funeral director W. W. Chambers Co.  
Address 517-11th St. S.E. Washington D.C.  
19. Aug. 19 19 46 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 46 at 10:55 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw him alive on 19  
Immediate cause of death acute congestive heart failure  
Due to cardiovascular renal disease  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
Signature Deputy Medical Examiner  
M.D. or other  
Address Forestville Md. Date signed 8-17-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

RECEIVED  
AUG 21 1946  
BUREAU V.B.

PLEASE WRITE FAIRLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08283  
243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 5 mos., 12 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 1 yr., 5 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 215 - 6th St. S. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

VINCENT TALBOTT

## 3.(b) Social Security Number

577-32-3006

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced  
 6.(b) Name of husband or wife Martha P. Talbott  
 6.(c) If alive, give age 51 years  
 7. Birth date of deceased (mo., day, yr.) October 12, 1892  
 8. AGE: Years 53 Months 9 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Upper Marlboro, Maryland  
 (Town, county, and state)  
 10. Usual occupation Watchman  
 11. Industry or business \_\_\_\_\_  
 12. Name William Talbott  
 13. Birthplace Anne Arundel Co., Maryland  
 14. Maiden name Laura Wells  
 15. Birthplace Prince George's Co., Maryland

16. Informant Decedent  
 Address \_\_\_\_\_  
 17. Burial Date thereof 8-5-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location \_\_\_\_\_  
 18. Funeral director Pitcher Bros  
 Address Upper Marlboro Md  
 19. 8/1/46 19 Rowland I. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 2, 46 at 1:25 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21, 45 to AUG. 2, 46  
 and that I last saw him alive on AUG. 2, 46  
 Immediate cause of death PULMONARY TUBERCULOSIS  
 DURATION 1 yr 9 mos.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Daniel Leo Finucane MD M. D. or other \_\_\_\_\_  
 Address Glenn Dale, Md. Date signed 8/2/46

RECEIVED  
AUG 9 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 492

## CERTIFICATE OF DEATH

Reg. Dist. No. 08284 245

## 1. PLACE OF DEATH:

County Prince Geo. C  
 City or town Riverdale  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince Geo C  
 City or town Riverdale  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4712 - Oliver St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary E. Tighe  
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 19 - 1893 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 53 Years Months Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Laurel, Md.  
 (If \_\_\_\_\_ county, and state)

10. Usual occupation Gov. Clerk11. Industry or business U.S. Treasury

12. Name Michael J. Tighe  
 13. Birthplace MD

14. Maiden name Mary Emma Ware  
 15. Birthplace MD

16. Informant Ruth Tighe  
 Address 4712 Oliver St Riverdale - MD

17. Buried Date thereof Aug. 10 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys Cemetery  
 Location Laurel - MD

18. Funeral director Levochauskis Co  
 Address Riverdale - MD

19. Aug 9 1946 James Sevy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 9<sup>30</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 1946 to August 8 1946  
 and that I last saw him alive on August 7 1946

Immediate cause of death

Cerebral metastases

DURATION

Due to

Carcinoma of the ovary

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Francis Ware MD

M. D. or other

Address 1246 Kelt St Date signed 8/8/46

RECEIVED

AUG 10 1946

BUREAU V S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-70

## CERTIFICATE OF DEATH

Reg. Dist. No. 08285 245

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Prinidal  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 mo. 2 days  
Hospital, institution, or street address where death occurred:  
Leland Memorial Hospital  
How long in hospital or institution? 1 mo. 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Beltsville Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 101 W. Grant Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

### 3. (a) FULL NAME

Tyson, Miss Anna Mary

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 3, 1876

8. AGE: Years 70 Months 1 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace N. Y.  
(Town, county, and state)

10. Usual occupation School teacher

11. Industry or business

FATHER 12. Name George Guston Tyson

13. Birthplace Ohio

MOTHER 14. Maiden name Calizabeth Jane McCusker

15. Birthplace Ireland

16. Informant Leland Memorial Hospital Record

Address Prinidal, Md.

17. Transportation Transpiration Date thereof Aug 14 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location New York

18. Funeral director J. Arthur's Walters

Address 254 Carroll St N.W. Wash. D.C.

19. Aug 14 1946 James Beery Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21 1945 to Aug 14 1946

and that I last saw him alive on August 12 1946

Immediate cause of death Acidosis and Malnutrition DURATION 5 mo.

Due to Carcinoma of tongue 1 year

and Metastasis to regional lymph glands 8 mo.

Other conditions Spastic colitis 5 mo.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wallace H. Brook M.D. M. D. or other

Address Beltsville Park 12, Md. Date signed 8-14-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 15 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08286 243

## 1. PLACE OF DEATH:

County Prince George's  
 City or town (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mos., 2 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 5 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1932 - First St. N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

EDWARD T WHALEN

## 3. (b) Social Security Number

577-18-7561

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 9, 1891

8. AGE: Years 55 Months - Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Paris, Tennessee  
 (Town, county, and state)

10. Usual occupation Operating Engineer

11. Industry or business \_\_\_\_\_

12. Name Thomas B. Whalen  
 13. Birthplace Hartford Co., Maryland

14. Maiden name Sara Atchison  
 15. Birthplace Ireland

16. Informant Decedent

Address \_\_\_\_\_

17. Removal Date thereof Aug. 31, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location to Washington, D.C.18. Funeral director F. Gaschi's SonsAddress Hyattsville, Md

19. Aug. 31, 1946 Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1946 at 10:59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/29/46 to 8/31/46  
 and that I last saw him alive on 8/31/46

Immediate cause of death Pulmonary Tuberculosis DURATION 8 mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other \_\_\_\_\_Address Glenn Dale, Md. Date signed 8/31/46

RECEIVED

SEP 7 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's

City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:  
Prince George's General

How long in hospital or institution? 3 Hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1018 16th N. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Virginia Ellen White

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Separated

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 28, 1913

8. AGE: Years 29 Months Days If less than one day  
hrs. min.9. Birthplace Henryville, Tenn.  
(Town, county, and state)  
Waitress

10. Usual occupation

11. Industry or business Restaurant

12. Name Joe C. White

13. Birthplace Unk

14. Maiden name Mattie S. Thomas

15. Birthplace Indiana

18. Informant Mrs. Heba A. Locke

Address 232 Tuckerman St., N. W., D.C.

17. Removal Date thereof Aug 7, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Washington, D.C.

Location

18. Funeral director J. Lee's Sons Co

Address 300-4 St. N. E. Wash. D.C.

19. 8/7 1946 Amanda Downey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1946 at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death

Hemorrhage and shock

## DURATION

Due to Fracture of the skull

Fracture of the left tibia and fibula

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of 8/7/46

Where did injury occur? Bladensburg P. G. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route # 1

Means of injury Pedestrian Struck by a car

Deputy Medical Examiner

23. SIGNATURE James J. [Signature] M. D. or other

Address Forestville, Md. Date signed 8/7/46



RECEIVED

AUG 9 1946

BUREAU V. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 18288 237

1. PLACE OF DEATH: <sup>1881</sup>  
 County Charles Prince Georges  
 City or town near Hughesville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? approx. 4 1/2 hours  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ernest Lee Winters

## 3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Cora H. Winters

7. Birth date of deceased (mo., day, yr.) 1881 8. (c) If alive, give age 65 years

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Alabama  
(Town, county, and state)10. Usual occupation Lawyer11. Industry or business Law12. Name Cora H. Winters13. Birthplace Little Rock, Arkansas14. Maiden name Unknown15. Birthplace or16. Informant Laurence C. WintersAddress 766 Harvard St. N.W. Wash. D.C.17. Burial Date thereof Aug. 15, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lincoln Memorial CemeteryLocation W. Washington, D.C.18. Funeral director W. Ernest JarvisAddress 1432 - You St. N.W. - Wash. D.C.

19. (Date rec'd by registrar) \_\_\_\_\_ 19. \_\_\_\_\_ Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. County D.C.City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. 766 Harvard St. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 19. 46 at 2 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 19. 46 to August 12 19. 46and that I last saw him alive on August 10 19. 46Immediate cause of death Acute myocarditisDue to Coronary Thrombosis

Due to \_\_\_\_\_

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Louis C. Gareis M.D.Address Hughesville, Md. M. D. or other \_\_\_\_\_Date signed Sept 30, 1946

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
OCT 4 1946  
BUREAU V S

Co. Health O.

COPY SENT TO

~~LOCAL REGISTRAR~~

DATE

10/4/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08289

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pro Geo Co.City or town Hyattsville Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4700 Rhode Island Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Richard woodruff

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Sadie woodruff.

7. Birth date of deceased (mo., day, yr.)

Set 15, 1890

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

56

hrs. min.

9. Birthplace

Pa  
(Town, county, and state)

10. Usual occupation

Gardener

11. Industry or business

MOTHER FATHER

12. Name

Douglas woodruff

13. Birthplace

Pa

14. Maiden name

Susan Hawthorne

15. Birthplace

Pa

16. Informant

Douglas woodruff, Jr.

Address

Hyattsville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 21, 1946.  
(month) (day) (year)

Cemetery or crematory

Methodist Cemetery

Location

Bladensburg Md.

18. Funeral director

F Gaschi Sons

Address

Hyattsville Md.

19.

(Date read by registrar)

Aug 21, 1946 James Berry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 18, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13, 1946, to Aug 18, 1946.  
and that I last saw him alive on Aug 17, 1946.

Immediate cause of death

Cerebral hemorrhage

DURATION

3 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W S Hudson M.D.  
M. D. or other

Address

513-8th St LaurelDate signed 8-18-46

MARGINAL RESERVE FOR BINDING

VS A15

9.45-1.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 22 1946  
BUREAU V. S.